2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

ADMINISTRATIVE RULES REVIEW

Table of Contents - Volume 1

Legislative Session 2004

IDAPA 15 - OFFICE OF THE GOVERNOR
IDAHO COMMISSION ON AGING

15.01.20 - Rules Governing Area Agency On Aging (AAA) Operations

Docket No. 15-0120-0301
Notice of Rulemaking - Pending Rule....6

Docket No. 15-0120-0301
Notice of Rulemaking - Temporary and Proposed Rule....7

IDAHO COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.30 - Business Enterprise Program

Docket No. 15-0230-0301
Notice of Rulemaking - Pending Rule....15

Docket No. 15-0230-0301
Notice of Rulemaking - Temporary and Proposed Rule....16

Docket No. 15-0230-0302
Notice of Rulemaking - Pending Rule....18

Docket No. 15-0230-0302
Notice Of Rulemaking - Proposed Rulemaking....19

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.19 - Rules Governing Food Safety And Sanitation Standards For Food Establishments

Docket No. 16-0219-0301 - (Chapter Repeal)
Notice of Rulemaking - Pending Rule....21

Docket No. 16-0219-0301 (Chapter Repeal)
Notice of Rulemaking - Proposed Rulemaking....22

16.02.19 - Food Safety And Sanitation Standards For Food Establishments

Docket No. 16-0219-0302 - (Chapter Rewrite)
Notice of Rulemaking - Pending Rule....23

Docket No. 16-0219-0302 (Chapter Rewrite)
Notice of Rulemaking - Proposed Rulemaking....25

16.03.01 - Rules Governing Eligibility For Medicaid For Families And Children

Docket No. 16-0301-0201
Notice of Rulemaking - Temporary and Proposed Rule....40

16.03.01 - Rules Governing Eligibility For Medicaid For Families And Children
Docket No. 16-0301-0201
Notice of Rulemaking - Pending Rule....50

Docket No. 16-0301-0301
Pending Rule and Amendment to Temporary Rule....51

Docket No. 16-0301-0301
Notice of Rulemaking - Temporary and Proposed Rule....53

Docket No. 16-0301-0302
Pending Rule and Amendment to Temporary Rule....57

Docket No. 16-0301-0302
Notice of Rulemaking - Temporary and Proposed Rule....58

16.03.03 - Rules Governing Child Support Services
Docket No. 16-0303-0301
Notice of Rulemaking - Pending Rule....62

Docket No. 16-0303-0301
Notice of Rulemaking - Temporary and Proposed Rule....63

16.03.04 - Rules Governing The Food Stamp Program In Idaho
Docket No. 16-0304-0202
Pending Rule and Amendment to Temporary Rule....65

Docket No. 16-0304-0202
Notice of Rulemaking - Temporary and Proposed Rule....67

Docket No. 16-0304-0301
Pending Rule and Amendment to Temporary Rule....78

Docket No. 16-0304-0301
Notice of Rulemaking - Temporary and Proposed Rule....81

16.03.05 - Rules Governing Eligibility For Aid To The Aged, Blind And Disabled (AABD)
Docket No. 16-0305-0203
Pending Rule and Amendment to Temporary Rule....94

Docket No. 16-0305-0203
Notice of Rulemaking - Temporary and Proposed Rule....96

Docket No. 16-0305-0301
Pending Rule and Amendment to Temporary Rule....102

Docket No. 16-0305-0301
Notice of Rulemaking - Temporary and Proposed Rule....105

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

16.03.05 - Rules Governing Eligibility For Aid To The Aged, Blind And Disabled
Docket No. 16-0305-0302
Pending Rule and Amendment to Temporary Rule 109

Docket No. 16-0305-0302
Notice of Rulemaking - Temporary and Proposed Rule 112

16.03.08 - Rules Governing Temporary Assistance For Families In Idaho (TAFI)
Docket No. 16-0308-0301
Pending Rule and Amendment to Temporary Rule 120

Docket No. 16-0308-0301
Notice of Rulemaking - Temporary and Proposed Rule 122

Docket No. 16-0308-0302
Notice of Rulemaking - Pending Rule.....126

Docket No. 16-0308-0302
Notice of Rulemaking - Temporary and Proposed Rule 127

16.03.09 - Rules Governing The Medical Assistance Program
Docket No. 16-0309-0212
Notice of Rulemaking - Pending Rule.....129

Docket No. 16-0309-0212
Notice of Rulemaking - Temporary and Proposed Rule 130

Docket No. 16-0309-0213
Notice of Rulemaking - Pending Rule.....142

Docket No. 16-0309-0213
Notice of Rulemaking - Temporary and Proposed Rule 143

Docket No. 16-0309-0214
Pending Rule and Amendment to Temporary Rule 145

Docket No. 16-0309-0214
Notice of Rulemaking - Temporary and Proposed Rule 150

Docket No. 16-0309-0215
Pending Rule and Amendment to Temporary Rule 155

Docket No. 16-0309-0215
Notice of Rulemaking - Temporary and Proposed Rule 160

16.03.09 - Rules Governing The Medical Assistance Program
Docket No. 16-0309-0217
Notice of Rulemaking - Pending Rule.....177

Docket No. 16-0309-0217
Notice of Rulemaking - Temporary and Proposed Rule 178

Docket No. 16-0309-0218
Notice of Rulemaking - Pending Rule.....194

Docket No. 16-0309-0218
Notice of Rulemaking - Temporary and Proposed Rule 195

Docket No. 16-0309-0301
Notice of Rulemaking - Pending Rule.....197

Docket No. 16-0309-0301
Notice of Rulemaking - Temporary and Proposed Rule 198

Docket No. 16-0309-0303
Pending Rule and Amendment to Temporary Rule 200

Docket No. 16-0309-0303
Notice of Rulemaking - Temporary and Proposed Rule 203

Docket No. 16-0309-0304
Pending Rule and Amendment to Temporary Rule 205

Docket No. 16-0309-0304
Notice of Rulemaking - Temporary and Proposed Rule 208

Docket No. 16-0309-0305
Notice of Rulemaking - Pending Rule.....231

Docket No. 16-0309-0305
Notice of Rulemaking - Temporary and Proposed Rule 232

Docket No. 16-0309-0306
Notice of Rulemaking - Pending Rule.....235

Docket No. 16-0309-0306
Notice of Rulemaking - Temporary and Proposed Rule 236

Docket No. 16-0309-0307
Pending Rule and Amendment to Temporary Rule 239

Docket No. 16-0309-0307
Notice of Rulemaking - Temporary and Proposed Rule 243

Docket No. 16-0309-0308
Notice of Rulemaking - Pending Rule.....263

16.03.09 - Rules Governing The Medical Assistance Program

Docket No. 16-0309-0308
Notice of Rulemaking - Temporary and Proposed Rule 264

Docket No. 16-0309-0309
Notice of Rulemaking - Pending Rule.....271

Docket No. 16-0309-0309
Notice of Rulemaking - Proposed Rule.....273

Docket No. 16-0309-0310
Pending Rule and Amendment to Temporary Rule 288

Docket No. 16-0309-0310
Notice of Rulemaking - Temporary and Proposed Rule 292

INDEX 304

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 15 - OFFICE OF THE GOVERNOR
IDAHO COMMISSION ON AGING

15.01.20 - RULES GOVERNING AREA AGENCY ON AGING (AAA) OPERATIONS

DOCKET NO. 15-0120-0301

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-5003(3), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the October 1, 2003 Idaho Administrative Bulletin, Volume 03-10, pages 162 through 169.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this pending rule, contact Sarah Scott, Program Operations Manager, at (208) 334-3833.

DATED this 23rd day of October 2003.

Sarah Scott, Program Operations Unit Manager
Idaho Commission on Aging
3380 Americana Terrace, Ste. 120
Boise, ID 83706
Telephone: (208) 334-3833
Facsimile: (208) 334-3033

IDAPA 15, TITLE 01, CHAPTER 20

RULES GOVERNING AREA AGENCY ON AGING (AAA) OPERATIONS

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-10, October 1, 2003, pages 162 through 169.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

IDAPA 15 - OFFICE OF THE GOVERNOR
IDAHO COMMISSION ON AGING

15.01.20 - RULES GOVERNING AREA AGENCY ON AGING (AAA) OPERATIONS

DOCKET NO. 15-0120-0301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 2, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 67-5003(3), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2003.

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

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

The proposed rule changes eliminate many existing requirements regarding the day-to-day operation of Area Agencies on Aging (AAAs). This will allow more flexibility in the AAAs' provision of services to the elderly through implementation of consumer choice programs. These AAAs are not state agencies but are subject to federal laws and rules.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

The rule changes confer a benefit to AAA's by removing unnecessary references and requirements in the rules that deal with the day-to-day operations of AAAs.

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01-811, negotiated rulemaking was not conducted because the temporary rulemaking confers a benefit to the affected AAA's.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and proposed rule, contact Sarah Scott, Program Operations Unit Manager, at (208) 334-3833.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2003.

DATED this 15th day of August, 2003.

Sarah Scott
Program Operations Unit Manager
Idaho Commission on Aging
3380 Americana Terrace, Ste. 120
Boise, Idaho 83706
Telephone: (208) 334-2220
Facsimile: (208) 334-3033

THE FOLLOWING IS THE TEXT OF DOCKET NO. 15-0120-0301

002. WRITTEN INTERPRETATION.
This agency may have written statements which pertain to the interpretation of the rules in this chapter. To obtain copies, contact the Idaho Commission on Aging by writing to the ~~*Director*~~ Administrator. ~~*(7-1-98)*~~(9-2-03)T

003. ADMINISTRATIVE APPEALS.
The ICOA ~~*and its AAAs*~~ shall provide ~~*service recipients and provider organizations*~~ AAAs with the opportunity to appeal administrative decisions~~*as follows:*~~. ~~*(7-1-98)*~~(9-2-03)T

~~***01. AAA Designation**. Any organization denied AAA designation through a competitive bidding process may appeal the decision in accordance with IDAPA 38.05.01, "Rules of the Division of Purchasing".* *(7-1-98)*~~

~~***02. AAA Provider Contracts**. Any organization denied an AAA contract through a competitive bidding process may appeal the decision in accordance with IDAPA 38.05.01, "Rules of the Division of Purchasing".* *(7-1-98)*~~

~~***03. Recipients Of Service**. AAAs shall develop fair and impartial hearing procedures and shall provide an opportunity for a hearing according to IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General," for any individual who is denied or terminated from a service.* *(7-1-98)*~~

004. -- 009. (RESERVED).

010. DEFINITIONS.
~~*Any item not specifically defined below shall have the same meaning as those listed in IDAPA 15.01.01, "Rules Governing Senior Services Program".* *(7-1-98)*~~

01. ~~***Bidder/Offerer/Proposer**. An eligible organizational entity which submits to the AAA a proposal to provide specific service(s).*~~ **Act**. The Idaho Senior Services Act (SS ACT). Programs and services established in Section 67-5001, et seq., Idaho Code. ~~*(7-1-98)*~~(9-2-03)T

02. ~~***Bidders' Conference**. A meeting conducted by the AAA to review the materials and information described in the RFP and to respond to questions from organizations that submit letters of intent and are interested in completing proposals on specific services.*~~ **Area Agency On Aging (AAA)**. Separate organizational unit within a multipurpose agency which functions only for purposes of serving as the area agency on aging that plans, develops, and implements services for older persons within a planning and service area. ~~*(7-1-98)*~~(9-2-03)T

03. ~~***Blind Negotiation**. A process which takes place between the AAA and bidders after the local evaluation committee has "scored" proposals and has determined that there is no significant difference, ten percent (10%), between bids. In this case, the AAA has the authority to select the proposal most advantageous to the AAA.*~~ **Area Plan**. Plan describing aging programs and services which an AAA is required to submit to the Idaho Commission on Aging, in accordance with the OAA, in order to receive OAA funding. ~~*(7-1-98)*~~(9-2-03)T

~~***04. Blind Review**. A proposal reviewing process which conceals the identity of the submitting organization.* *(7-1-99)*~~

0~~5~~4. **Contract**. A legally binding, written agreement between two (2) or more parties which outlines the terms and provisions to which both parties agree. (7-1-98)

05. **Idaho Commission On Aging (ICOA)**. State agency that plans, sets priorities, coordinates, develops policy, and evaluates state activities relative to the objectives of the OAA. (9-2-03)T

06. ~~***Evaluation Committee**. A group of individuals selected to review proposing organizations'*~~

~~*completed proposals.*~~ **Older Americans Act (OAA).** Federal law authorizing funding to states for supportive and nutrition services for the elderly. ~~*(7-1-98)*~~(9-2-03)T

07. ~~***Letter Of Intent****. A written communication submitted by a potential bidder soliciting a request for proposal to provide a specific service.*~~ **Planning And Service Area (PSA).** ICOA designated geographical area within Idaho for which an AAA is responsible. ~~*(7-1-98)*~~(9-2-03)T

~~***08.*** ***Performance Based Agreement****. A contract or grant which expresses priorities and directions through a statement of work and which serves as the basis for program review/assessment through the year. (7-1-98)*~~

~~***09.*** ***Request For Proposal (RFP)****. A document issued by the AAA, describing in detail the service to be contracted and how it is to be delivered. (7-1-98)*~~

~~***10.*** ***Sole Source****. Documentation that only one (1) eligible, available provider is interested in providing a specific service. (7-1-98)*~~

~~***11.*** ***Statement Of Work****. The precise, definitive statement of what is expected of the provider. It shall answer such questions as what, how, when, where, and sometimes, why. (7-1-98)*~~

011. -- 019. (RESERVED).

020. PLANNING AND SERVICE AREA (PSA) DESIGNATION.
The ICOA ~~*shall*~~ has divided the state into PSAs in accordance with Section 305 of the OAA, as amended. ~~*(7-1-98)*~~(9-2-03)T

021. AAA ~~*DESIGNATION*~~.

01. AAA Designation. The ICOA shall accept applications for AAA designation in accordance with Section 305 of the OAA. (7-1-98)

0~~*2*~~2. ~~***REVOKING***~~ **Revocation Of AAA Designation**. The ICOA may revoke the designation of an AAA ~~*in accordance with conditions*~~ as specified in ~~*45 CFR 1321.35*~~ OAA and the federal regulations thereunder. ~~*(7-1-98)*~~(9-2-03)T

~~***01.*** ***Due Process****. The ICOA shall provide due process in revoking AAA designation in accordance with Section 003 of this chapter and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General". (7-1-98)*~~

~~***02.*** ***Assumption Of Responsibilities****. Upon revocation of AAA designation, the ICOA shall assume the responsibilities of the AAA in accordance with 45 CFR 1321.35. (7-1-98)*~~

03. Denial Of AAA Designation. Any organization denied AAA designation through a competitive bidding process may appeal the decision to the Administrator of ICOA. (9-2-03)T

~~***023. -- 030. (RESERVED).***~~

0~~*31*~~4. Limit On The Number Of Area Agencies And PSA'S. In order to maximize funding for services that directly benefit the elderly, the ~~*ICOA shall limit the*~~ number of PSAs and AAAs is limited to six (6). ~~*(7-1-98)*~~(9-2-03)T

~~***032. DISTRIBUTION OF FUNDS.***~~
~~*In accordance with Section 305 of the OAA, the ICOA shall develop a formula for distribution of funds and shall publish the formula for review and comment. (7-1-98)*~~

~~***033. AWARDING OF FUNDS.***~~
~~*The ICOA shall award funds to AAAs through performance-based agreements set forth in a prescribed format and in accordance with guidelines developed by the ICOA. (7-1-98)*~~

0~~34~~22. AAA BUDGET~~S~~ FORMS AND REVISIONS.

01. Budget Forms. ~~*As part of their agreement with the ICOA, e*~~Each AAA shall submit, on forms provided by the ICOA, a budget for agency operations. The AAA shall maintain sufficiently detailed ~~*in*~~ budget and expenditure records to respond to requests ~~*by*~~ for information from the ICOA, Administration on Aging, legislators, or the general public. ~~*(7-1-98)*~~(9-2-03)T

02. Budget Revisions. Requests for approval of ~~*B*~~budget revisions shall be ~~*provided*~~ made in writing to the ICOA: ~~*(7-1-98)*~~(9-2-03)T

a. In order to process transfers ~~*in*~~ between Title III programs; ~~*(7-1-98)*~~(9-2-03)T

b. To reflect holdbacks or midyear increases in state or federal spending; or (7-1-98)

c. If there is a change in spending which exceeds ten percent (10%) ~~*or ten thousand dollars ($10,000) within state or federal budgets*~~ of any line item in the comprehensive budget summary. ~~*(7-1-98)*~~(9-2-03)T

0~~35~~23. -- 040. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

042. CONTRACT MANAGEMENT REQUIREMENTS.
AAAs shall ~~*follow State*~~ adhere to all applicable federal contracting and ~~*P*~~procurement ~~*Practices*~~ requirements in awarding subcontracts~~*, in accordance with the ICOA Area Agency on Aging Operations Manual, Chapter 4*~~. ~~*(7-1-99)*~~(9-2-03)T

~~***01. Competitive Bids**. The AAAs shall accept competitive bids and shall develop contracts for provision of programs and services authorized and funded under the OAA of 1965, as amended, and Sections 67-5007 and 5008, Idaho Code. (7-1-98)*~~

0~~2~~1. ~~*Incorporation Of*~~ Non-Profit Agency Contractors. ~~*All private non-profit agency contractors shall be*~~ AAAs may subcontract with private, non-profit agencies that are incorporated as 501(c)(3) organizations. (9-2-03)T

02. AAA Provider Subcontracts. All subcontracts between the AAA and service providers shall contain sufficient program and financial information to ensure all activities comply with the Area Plan, the ~~*Act*~~ OAA, federal regulations, the SS Act, and the rules of the ICOA. ~~*(7-1-98)*~~(9-2-03)T

03. ~~*Multi-Year*~~ Contracts Term. ~~*The*~~ Each AAA may award multi-year subcontracts not to exceed four (4) years. (9-2-03)T

a. ~~*The*~~ Each AAA shall maintain documentation ~~*which*~~ satisfactory to ICOA that justifies the reason(s) a multi-year subcontract was awarded. Justification for a multi-year subcontract ~~*shall*~~ may include, but is not limited to, the following: ~~*(7-1-98)*~~(9-2-03)T

~~*a*~~i. More than one (1) year is necessary to complete the project or service; (7-1-98)

~~*b*~~ii. More than one (1) year is necessary to justify substantial cost savings; or ~~*(7-1-98)*~~(9-2-03)T

~~*c*~~iii. A multi-year subcontract award is necessary to allow ~~*the*~~ a provider the opportunity to increase and demonstrate capacity to operate a particular service~~;~~. ~~*or*~~ ~~*(7-1-98)*~~(9-2-03)T

~~*d*~~**b.** No AAA shall continue a multi-year subcontract unless the ~~*R*~~results of evaluation justify

continuance of the subcontract ~~*with the existing provider*~~. ~~*(7-1-98)*~~(9-2-03)T

04. AAA Provider Appeals. ~~*When there is competition for specific services, the bidder who does not receive the award has a right to appeal the decision. The AAA is required to include information in the RFP describing the appeal procedure available to non-selected organizations.*~~ AAAs shall develop fair and impartial hearing procedures and shall provide an opportunity for a hearing for any organization denied a subcontract with the AAA. ~~*(7-1-98)*~~(9-2-03)T

~~***05. Noncompetitive Negotiation**. Noncompetitive negotiation of contracts is allowable if the AAA follows IDAPA 38.05.01, "Rules of the Division of Purchasing". (7-1-98)***

~~***06. Execution Of Contracts**. The AAA is required to demonstrate prudent execution of any agreements (contracts) between the agency and public or private (for-profit or non-profit) organizations receiving state or federal funds. (7-1-98)***

~~***07. Standard Contracts**. The AAA shall develop a standard contract format to be used in those instances where no special format is required by ICOA. The AAA shall develop procedures assuring that recipients of contracts are made fully aware of responsibilities and obligations under the approved Area Plan. Upon approval of contracts under the Area Plan, the AAA shall maintain file copies of contracts, criteria used to approve contracts, copies of the approved proposals, and any amendments. (7-1-98)***

~~***08. Contract Management Activities**. Contract management encompasses those AAA activities which shall take place after a contract has been executed. The AAA shall assure that each executed contract is performed, as written, by both the provider and the AAA. (7-1-98)***

~~***09. Contract Management Staff**. The AAA shall assign a staff person to assure that contracts are properly administered, monitored, and reviewed on a continuing basis. (7-1-98)***

~~***10. Close Out Or Termination**. The close out or termination phase of a contract begins when one (1) or more of certain steps are initiated to bring the contract to an end and concludes with the final settlement of all contract matters. Close out may entail such steps as: (7-1-98)***

~~***a.** Issuance of stop work orders, termination notices, etc.; (7-1-98)*~~

~~***b.** Negotiation and adjudication of disputes and appeals; (7-1-98)*~~

~~***c.** Negotiation and execution of releases; (7-1-98)*~~

~~***d.** Final payment; and (7-1-98)*~~

~~***e.** Other pertinent procedures. (7-1-98)*~~

~~***11. Close Out Or Termination Procedures**. Close out or termination includes the following procedures: (7-1-98)***

~~***a.** Upon termination of contract, the AAA may require the provider to return any property specifically produced or acquired under the contract. The provisions of the "Treatment of Assets" clause contained in the contract document shall apply in such property transfer. (7-1-98)*~~

~~***b.** The AAA shall pay the provider the agreed upon price, if separately stated, for goods and services accepted by the AAA and for the amount agreed upon by the provider and the AAA for: (7-1-98)*~~

~~*i. Completed work and services for which no separate price is stated; (7-1-98)*~~

~~*ii. Partially completed work and services; (7-1-98)*~~

~~*iii. Other property or services which are accepted by the AAA; and (7-1-98)*~~

~~*iv. The protection and preservation of property, unless the termination is for default, in which case the AAA shall determine the extent of liability of the contracting agency.* (7-1-98)~~

~~***c.*** *Failure to agree with such determination shall be regarded as a dispute concerning a question of fact within the meaning of the "Disputes" clause of the written contract document. The AAA may withhold, from any amounts due the provider for such completed work or services, such sum as the AAA determines to be necessary to protect the AAA from loss resulting from outstanding liens or claims of former holders.* (7-1-98)~~

~~***12. Non-Exclusivity Of Rights And Remedies****. The rights and remedies of the AAA provided in this part shall not be exclusive and are in addition to any other rights and remedies provided by law or under the terms of the contract document.* (7-1-98)~~

~~***13. Provider Termination Responsibilities****. After receipt of a notice of termination, the provider shall:* (7-1-98)~~

~~***a.*** *Stop work under the contract on the date and to the extent specified in the notice;* (7-1-98)~~

~~***b.*** *Place no further orders or subcontracts for materials, services, or facilities except as may be necessary for completion of such portion of the work under the contract as is not terminated;* (7-1-98)~~

~~***c.*** *Settle all outstanding liabilities and all claims arising out of such termination of order and contract.* (7-1-98)~~

~~***d.*** *Transfer title to the AAA and deliver in the manner, at the time, and to the extent, if any, directed by the AAA, any property which, if the contract had been completed, would have been required to be furnished to the AAA;* (7-1-98)~~

~~***e.*** *Complete performance of such part of the work as shall not have been terminated by the AAA; and* (7-1-98)~~

~~***f.*** *Take such action as may be necessary, or as the AAA may direct, for the protection and preservation of the property related to the contract, which is in the possession of the provider and in which the AAA has or may acquire an interest.* (7-1-98)~~

043. -- 050. (RESERVED).

051. AREA ADVISORY COUNCILS ON AGING.

01. Establishment Of Council. The AAA shall establish an advisory council in accordance with the requirements of the OAA, as amended, and all pertinent federal regulations. (7-1-98)

02. Council Meetings. ~~*In addition to the federal requirements, the*~~ Each advisory ~~C~~council shall ~~*hold*~~ meet at least two (2) ~~*full council meetings each year, and committees of the Council shall meet at least four (4)*~~ times each year. ~~*(7-1-98)*~~(9-2-03)T

~~***03. Local Elected Officials****. The Council shall include at least two (2) local elected officials from different jurisdictions.* (7-1-98)~~

~~***04. Ethnic Minority Representation****. The Council shall include at least one (1) representative from each racial or ethnic minority community located within the PSA. For purposes of this subsection, a community is a unified group of African American, Asian/Pacific Island, Hispanic, Native American, or other individuals sharing common origin, history, culture, or interests living in a particular geographic area.* (7-1-98)~~

0~~*5*~~3. Conflict Of Interest. ~~*Staff paid under the Area Plan*~~ AAA employees, or members of the immediate families of ~~*paid staff members*~~ AAA employees, shall not serve on the advisory ~~C~~council. ~~*(7-1-98)*~~(9-2-03)T

0~~6~~4. **By-Laws**. The advisory ~~C~~council shall adopt and operate according to by-laws. ~~*adopted by the Council. Such by-laws shall include:*~~ ~~*(7-1-98)*~~(9-2-03)T

~~***a.*** *Name of Council.* *(7-1-98)*~~

~~***b.*** *Council responsibilities.* *(7-1-98)*~~

~~***c.*** *Selection and composition of Council members.* *(7-1-98)*~~

~~***d.*** *Term of Office.* *(7-1-98)*~~

~~***e.*** *Council meetings.* *(7-1-98)*~~

~~***f.*** *Election, duties, and term of office of officers.* *(7-1-98)*~~

~~***g.*** *Committees of the Councils and their responsibilities.* *(7-1-98)*~~

~~***h.*** *Provisions for adoption and amendment of by-laws.* *(7-1-98)*~~

052. AREA PLANS.
Each AAA shall submit a four (4) year area plan to the ICOA by close of business ~~*October 15, 1998*~~ January 1, 2002, and by October 15 every four (4) years thereafter. Annual updates shall be submitted by October 15 of each year. The area plan and annual updates shall be submitted in a uniform format prescribed by the ICOA to meet the requirements of the OAA and all pertinent federal regulations. ~~*(3-30-01)*~~(9-2-03)T

053. SERVICE PRIORITY AND APPEALS.

01. Service Priority. Pursuant to the OAA, ~~*E*~~each AAA shall ensure that all service providers prioritize service delivery to those older individuals having the greatest economic and~~*/or*~~ social need, with particular attention to low-income minority individuals and individuals residing in rural areas. ~~*(7-1-98)*~~(9-2-03)T

02. Denial Or Termination Of Service. AAAs shall develop fair and impartial hearing procedures and shall provide an opportunity for a hearing for any individual who is denied or terminated from a service. (9-2-03)T

054. ELIGIBILITY.

~~***01. Eligibility For Act Programs.***~~ Persons age sixty (60) years and older who are residents of the state of Idaho are eligible for SS Act ~~*P*~~programs. ~~*(7-1-98)*~~(9-2-03)T

~~***02. Eligibility For OAA Programs.*** *Persons age sixty (60) years and older and their spouse, regardless of residency, are eligible for OAA programs with the exception of the Senior Community Service Employment Program (SCSEP). Eligibility for the SCSEP program is fifty-five (55) years and older.* *(7-1-98)*~~

055. AAA ASSESSMENTS OF PROVIDERS.
Every other year each AAA~~*s*~~ shall conduct, at a minimum, ~~*bi-annual*~~ one (1) on-site assessments of each of ~~*their*~~ its providers. Such assessments shall comply with the terms of the ~~*performance-based agreement*~~ AAA contract with the ICOA. Such reviews shall be on file for ICOA review. ~~*(7-1-98)*~~(9-2-03)T

056. REPORTING REQUIREMENTS.

01. Reporting Forms. Each AAA shall submit to the ICOA such reports as are specified by the ICOA, in such format and on such schedule as is established by the ICOA, in fulfillment of all federal and state requirements. (7-1-98)

02. Verification Of Service Provider Reports. The AAAs shall conduct ongoing verification of service provider reports in accordance with the terms of the ~~*performance-based agreement*~~ contract with the ICOA.

~~*(7-1-99)*~~(9-2-03)T

03. Reporting Deficiencies. If reports are late, incorrect, or incomplete, the ICOA shall withhold funds from the AAA, in accordance with terms of the ~~*performance-based agreement*~~ contract between the ICOA and the AAA, until a correct report is received by the ICOA. ~~*(7-1-99)*~~(9-2-03)T

~~***057. COMPLAINTS AGAINST AAA EMPLOYEES.***~~
~~*When complaints are received alleging improper or illegal actions on the part of AAA employees who are providing direct services to clients, the AAA shall refer the complaint to the ICOA. The ICOA shall conduct an investigation, develop findings, and make recommendations to the AAA.* *(7-1-98)*~~

05~~*8*~~7. CIVIL RIGHTS.
Neither the AAAs nor their providers shall violate any state or federal law regarding civil rights and shall provide all services and functions funded by the ICOA, affected by rule of the ICOA or provided for by contract with the ICOA without discrimination on the basis of race, color, national origin, age, gender, physical or mental impairment, or on any other basis prohibited by law. (7-1-98)

05~~*9*~~8. -- 065. (RESERVED).

066. FINANCIAL MANAGEMENT.

01. Regulations. Area agencies and service providers shall meet the financial management requirements of 45 CFR, Section 74 and Section 92. (7-1-98)

~~***02. Timing Of Expenditures****. Expenditures for a program shall not be made before the beginning date of the contract, nor after the ending date, except for accounts payable and other written obligations. Those obligations shall be paid within sixty (60) days of the end of the fiscal year.* *(7-1-98)*~~

0~~*67*~~2. Allowable Costs. Allowable costs are delineated in the OAA, Cost Principles for Colleges and Universities, OMB Circular A-21, and Cost Principles for Non-Profit Organizations, OMB ~~*c*~~Circular A-122. These cost principles shall apply to the expenditure of federal funds, ~~*and*~~ as well as any state or local funds which are reported as match for federal funds. In-kind contributions shall benefit the program for which they are reported as match. No expenditure shall be used as match if it has been or will be counted as match for another award of federal or state funds. ~~*(7-1-98)*~~(9-2-03)T

~~***068. COLLECTION AND ACCOUNTABILITY OF PARTICIPANT CONTRIBUTIONS.***~~

~~***01. Participant Contribution Confidentiality****. All participants shall be given the opportunity to contribute to programs operated with Administration on Aging funds. The method of collection shall respect the privacy of the participant, and provide for confidentiality of the fact and amount of the contribution.* *(7-1-98)*~~

~~***02. Payment For Service****. Persons under the age of sixty (60), who are not spouses of eligible participants, shall pay the full cost of meals, as published by the meal provider. No eligible person shall be denied services because of inability to pay.* *(7-1-98)*~~

~~***03. Used To Support Service****. Service contributions shall be used to support the service from which they were generated.* *(7-1-98)*~~

~~***04. Security For Cash Collections****. The service provider collecting funds shall provide for security of cash collected by having two (2) people involved in the collection and counting process.* *(7-1-98)*~~

0~~*69*~~3. Audits~~*-Of AAA's And Service Providers*~~. All AAAs and service providers receiving more than three hundred thousand dollars ($300,000) of federal funds per year shall be audited per the Single Audit Act of 1996 and OMB Circular A-133. ~~*No audit is required for service providers receiving state funds or less than three hundred thousand dollars ($300,000) in federal funds per year.* *(7-1-98)*~~(9-2-03)T

0~~*70*~~67. -- 999. (RESERVED).

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 15 - OFFICE OF THE GOVERNOR
IDAHO COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.30 - BUSINESS ENTERPRISE PROGRAM

DOCKET NO. 15-0230-0301

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-5401, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the June 4, 2003 Idaho Administrative Bulletin, Volume 03-6, pages 37 and 38.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning this pending rule, contact Michael Graham, Administrator, at (208) 334-3220.

DATED this 9th day of July, 2003.

Michael Graham, Administrator
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
P. O. Box 83720
Boise, ID 83720-0012
Phone: (208) 334-3220
Fax: (208) 334-2963

IDAPA 15, TITLE 02, CHAPTER 30

BUSINESS ENTERPRISE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-6, June 4, 2003, pages 37 and 38.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

IDAPA 15 - OFFICE OF THE GOVERNOR
IDAHO COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.30 - BUSINESS ENTERPRISE PROGRAM

DOCKET NO. 15-0230-0301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 31, 2003.

AUTHORITY: In compliance with Section 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 67-5401, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 18, 2003.

The hearing sites 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:

This temporary rule proposes that the penalty be removed in the rule that penalizes vendors participating in the Blind Enterprise Program when they withdraw funds from their private retirement accounts.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Confers a benefit. Adoption of the rule as a temporary rule with immediate effect is necessary to allow participants in the Idaho Blind Enterprise Program to have immediate access to their private retirement accounts and release the Commission from the duty to supervise and monitor these private accounts.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the proposed rulemaking was requested by a vote of the affected parties: the vendors participating in the Blind Enterprise Program.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Michael Graham, Administrator, at (208) 334-3220.

Anyone may submit written comments regarding this temporary and proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25, 2003.

DATED this 28th day of April, 2003.

Michael Graham
Administrator
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
P. O. Box 83720
Boise, ID 83720-0012
Phone: (208) 334-3220
Fax: (208) 334-2963

THE FOLLOWING IS THE TEXT OF DOCKET NO. 15-0230-0301

120. OPERATOR BENEFITS.

01. Vending Machine Income. The Program shall provide licensees with information regarding benefits. Upon a majority vote of licensees, the Program may retain vending machine income from federal property in accordance with 34 CFR 395.8(a). Such income may be used for the establishment and maintenance of retirement or pension plans, for health insurance contributions, and for the provision of paid sick leave and vacation time for operators. Distribution of benefit payments shall be determined by a majority vote of licensees and established as policy. (3-15-02)

02. Eligibility. Only operators of a primary location pursuant to an agreement shall be eligible to receive benefits. There shall be a ninety (90) day waiting period before a new operator is eligible to receive benefits. Benefit payments will not be interrupted when an operator transfers from one primary location to another. Benefits shall be paid only after the appropriate documentation is submitted to the Program. (3-15-02)

03. Medical Insurance. If a majority of licensees determines that operators shall be reimbursed for medical insurance premiums, operators shall be responsible for acquiring their own policies. The Program shall reimburse the operator in an amount determined by the vote of licensees. Operators shall provide documentation to the Program proving payment of their premiums, prior to any reimbursement. (3-15-02)

04. Retirement And Pension Accounts. If a majority vote of licensees determines that operators shall have retirement accounts, the Program shall deposit into approved retirement accounts an amount determined by a majority vote of licensees, up to the maximum federal allowance for IRAs per year. The ~~F~~funds shall be deposited on a monthly basis directly into each operator's retirement account. ~~*Not later than February 21 of each year, each Operator shall provide the Program a statement, signed and notarized, that the operator has made no unauthorized withdrawals from his retirement account. Deposit of funds shall be withheld from any operator's account until their statement is received. Withdrawals must have prior approval of the Program and shall only be made for uses approved for retirement accounts. If unauthorized withdrawals are made from an account, the operator shall have their License and Operating Agreement terminated.*~~ ~~*(3-15-02)*~~(1-31-03)T

05. Sick Leave And Vacation Funds. If a majority vote of licensees determines that operators shall have sick and/or vacation leave funds, the Program shall remit to each operator an amount determined by a majority vote of licensees. (3-15-02)

06. Non Fully Funded Benefits. If funds are not available for full payment of benefits, as voted by the licensees, the Program may pro-rate the payments from available funds, unless another method of disbursement of non-fully funded benefits was voted by a majority of the licensees. (3-15-02)

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 15 - OFFICE OF THE GOVERNOR
IDAHO COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.30 - BUSINESS ENTERPRISE PROGRAM

DOCKET NO. 15-0230-0302

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-5407, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the October 1, 2003 Idaho Administrative Bulletin, Volume 03-10, pages 170 and 171.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Angela Roan, Acting Administrator, at (208) 334-3220.

DATED this 28th day of October, 2003.

Angela Roan, Acting Administrator
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
P. O. Box 83720, Boise, Idaho 83720-0012
Telephone: (208) 334-3220
Facsimile: (208) 334-2963

IDAPA 15, TITLE 02, CHAPTER 30

BUSINESS ENTERPRISE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-10, October 1, 2003, pages 170 and 171.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

IDAPA 15 - OFFICE OF THE GOVERNOR
IDAHO COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.30 - BUSINESS ENTERPRISE PROGRAM

DOCKET NO. 15-0230-0302

NOTICE OF RULEMAKING - PROPOSED RULEMAKING

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-5407, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2003.

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

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking: The proposed rules incorporate by reference the Commission's Business Enterprise Allowable Cost Manual, which sets forth performance standards for the operation of a primary location, and provide for discipline of vendors who are not operating in compliance with those standards. The rules are needed to provide standards for the operation of snack bar, vending, and cafeteria sites (that constitute primary locations under the Business Enterprise Program).

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

NEGOTIATED RULEMAKING: Informal negotiated rulemaking was conducted.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rule, contact Angela Roan, Acting Administrator, at (208) 334-3220.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2003.

DATED this 20th day of August, 2003.

Angela Roan
Acting Administrator
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
P. O. Box 83720, Boise, Idaho 83720-0012
Telephone: (208) 334-3220
Facsimile: (208) 334-2963

THE FOLLOWING IS THE TEXT OF DOCKET NO. 15-0230-0302

004. INCORPORATION BY REFERENCE.
~~*There are no documents that have*~~ The Business Enterprise Program Allowable Cost Manual, dated August 15, 2003, which has been issued by the Commission for the Blind and Visually Impaired, has been incorporated by reference

into this rule. ~~*(3-15-02)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

006. PUBLIC RECORDS ACT COMPLIANCE.
~~*The records associated with the Business Enterprise Program*~~ All rules contained in this chapter are subject to and in compliance with the ~~*provisions of the*~~ Idaho Public Records Act~~,~~ (Title 9, Chapter ~~*1*~~3, Idaho Code). ~~*(3-15-02)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

100. SETTING ASIDE OF FUNDS.

01. Set Aside. Maintenance and Purchase of New Equipment. The Commission may set aside, or cause to be set aside, from the net profit of the operation of facilities, funds for the purposes of: (3-1-93)

a. Maintenance and replacement of equipment; (3-1-93)

b. Purchase of new equipment. (3-1-93)

02. Other Purposes Allowed By The Randolph-Sheppard Act. The Commission reserves the right to use set aside funds for other purposes as permitted in accordance with the provisions of the Randolph-Sheppard Act and Federal Rules and Regulations. (3-1-93)

03. Approval By The United States Department Of Education. The funds set aside for those specified purposes shall not exceed the amount determined reasonable by the Rehabilitation Services Administration Commissioner, U.S. Department of Education. (3-1-93)

04. Record Of Expenditures. The charge for each of the program purposes cited shall be determined on the basis of records of expenditures made for each of these purposes over a reasonable period of time with allowances for improving services, fluctuations in costs and program expansion. Adequate records shall be maintained to support the charges for each of the purposes cited. (3-1-93)

05. Increases. At no time shall the set aside charges be increased without prior consultation with the Committee. (3-1-93)

06. Review Of Schedule Of Funds. The schedule of funds to be set aside shall be reviewed periodically by the Supervisor and the Committee. After reviewing the accounting records and other criteria pertinent to the administration of the Program, it may be necessary to revise the set aside payment schedule. (3-1-93)

07. Income With No Program Operator. Vending machine income received from Federal sites where there is no licensed Program operator shall be used for those purposes designated by the Committee in accordance with Title 34, Part 395.8, of the Code of Federal Regulations. (3-1-93)

08. Performance Standards For A Primary Location. Each vendor operating a primary location is required to meet the performance standards set forth in the incorporated Business Enterprise Allowable Cost Manual. Failure to meet performance standards as set forth in the Business Enterprise Program Allowable Cost Manual will result in the vendor being placed on probation (see Subsection 040.06). Continued failure to meet the performance standards during the probationary period will result in the termination of the vendor's agreement or license (see Sections 040 and 140). (____)

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.19 - RULES GOVERNING FOOD SAFETY AND SANITATION STANDARDS FOR FOOD ESTABLISHMENTS

DOCKET NO. 16-0219-0301 - (CHAPTER REPEAL)

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections (s)37-121 and 39-1603, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the August 6, 2003 Administrative Bulletin, Volume 03-8, page 38.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mary Valentine at (208) 334-5936.

DATED this 19th day of September, 2003.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16, TITLE 02, CHAPTER 19

RULES GOVERNING FOOD SAFETY AND SANITATION STANDARDS FOR FOOD ESTABLISHMENTS

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-8, August 6, 2003, page 38.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.19 - RULES GOVERNING FOOD SAFETY AND SANITATION STANDARDS FOR FOOD ESTABLISHMENTS (UNICODE)

DOCKET NO. 16-0219-0301 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - PROPOSED RULEMAKING

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

Monday, August 18, 2003	**Wednesday, August 20, 2003**	**Wednesday, August 27, 2003**
7:00 - 9:00 p.m.	**7:00 - 9:00 p.m.**	**7:00 - 9:00 p.m.**
Holiday Inn Boise	**Holiday Inn Pocatello**	**Shilo Inn Coeur d'Alene**
3300 Vista Ave	**1399 Bench Road**	**702 Appleway**
Boise, ID	**Pocatello, ID**	**Coeur d'Alene, ID**

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

This entire chapter of rules, IDAPA 16.02.19, "Rules Governing Food Safety and Sanitation Standards for Food Establishments (UNICODE)," is being repealed and rewritten under Docket 16-0219-0302. The current standards for the State of Idaho are being repealed to set Idaho standards that will be more consistent with other states standards on food safety.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted by the Department of Health and Welfare by holding meetings and receiving input and agreement from the Idaho Food Safety Advisory Committee. The committee was comprised of representatives of the food industry, academic representatives and regulatory representatives.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Mary Valentine at (208) 334-5936.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before August 27, 2003.

DATED this 23rd day of June, 2003.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720 , Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

IDAPA 16.02.19 IS BEING REPEALED IN ITS ENTIRETY

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.19 - FOOD SAFETY AND SANITATION STANDARDS FOR FOOD ESTABLISHMENTS

DOCKET NO. 16-0219-0302 - (CHAPTER REWRITE)

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s)37-121 and 39-1603, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted with a modification to the 2001 Food Code to add Section 201-Assignment of Person in Charge. This addition is being made in response to public comments received during public hearings and the written comment period. The original text of the proposed rule was published in the August 6, 2003 Administrative Bulletin, Volume 03-8, pages 39 through 53.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mary Valentine at (208) 334-5936.

DATED this 19th day of September, 2003.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone
(208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

IDAPA 16, TITLE 02, CHAPTER 19

RULES GOVERNING FOOD SAFETY AND SANITATION STANDARDS FOR FOOD ESTABLISHMENTS

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-8, August 6, 2003, pages 39 through 53.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

Language That Has Been Deleted From The Original Proposed Rule Has Been Removed And New Language Is Shown In Italics

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THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0219-0302

201. ASSIGNMENT OF PERSON IN CHARGE.
Modification to Section 2-101.11. The license holder shall be the person in charge or shall designate a person in charge and shall ensure that a person in charge is present during all hours of food preparation and service. ( )

20~~1~~2. -- 209. (RESERVED).

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.19 - FOOD SAFETY AND SANITATION STANDARDS FOR FOOD ESTABLISHMENTS

DOCKET NO. 16-0219-0302 (CHAPTER REWRITE)

NOTICE OF RULEMAKING - PROPOSED RULEMAKING

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

Monday, August 18, 2003	**Wednesday, August 20, 2003**	**Wednesday, August 27, 2003**
7:00 - 9:00 p.m.	**7:00 - 9:00 p.m.**	**7:00 - 9:00 p.m.**
Holiday Inn Boise	**Holiday Inn Pocatello**	**Shilo Inn Coeur d'Alene**
3300 Vista Ave	**1399 Bench Road**	**702 Appleway**
Boise, ID	**Pocatello, ID**	**Coeur d'Alene, ID**

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 non-technical explanation of the substance and purpose of the proposed rule making:

This chapter of rules is being rewritten to update Idaho's food safety standards that apply to commercial food establishments. The current standards for the State of Idaho are being repealed in Docket 16-0219-0301. This new chapter will set standards to be more consistent with other states on food safety. These rules incorporate the "Food Code, 2001 Recommendations of the United States Public Health Service Food and Drug Administration," with modifications and additions.

The text of the 2001 Food Code may be viewed on line at "http://www.cfasan.fda.gov". It is published by the National Technical Information Service, Publication PB 2002-100819. A certified copy of this publication may be reviewed at the main office of the Department of Health and Welfare.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted by the Department of Health and Welfare by holding meetings and receiving input and agreement from the Idaho Food Safety Advisory Committee. The committee was comprised of representatives of the food industry, academic representatives and regulatory representatives.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Mary Valentine at (208) 334-5936.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before August 27, 2003.

DATED this 23rd day of June, 2003.

Sherri Kovach
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0219-0302

IDAPA 16, TITLE 02, CHAPTER 19

16.02.19 - FOOD SAFETY AND SANITATION STANDARDS FOR FOOD ESTABLISHMENTS

000. LEGAL AUTHORITY.
The State of Idaho Board of Health and Welfare is authorized under Sections 37-121 and 39-1603, Idaho Code, to adopt rules for the regulation of food establishments to protect public health. ( )

001. TITLE, SCOPE AND APPLICABILITY.

01. Title. The title of this chapter is IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments," and may also be known as the Idaho Food Code. ( )

02. Scope. The purpose of these rules is to establish standards for the provision of safe, unadulterated and honestly presented food for consumption by the public. These rules provide requirements for licensing, inspections, review of plans, employee restriction, and license suspensions for food establishments and food processing plants. Also included are definitions and set standards for management, personnel, food operations, equipment and facilities. ( )

03. These Rules Apply To Food Establishments. Food establishments as defined in Section 39-1602, Idaho Code, must follow these rules. Those facilities include but are not limited to the following: ( )

a. Restaurants, catering facilities, taverns, kiosks, vending facilities, commissaries, cafeterias, mobile food facilities, temporary food facilities; and ( )

b. Schools, senior centers, hospitals, residential care and treatment facilities, nursing homes, correctional facilities, camps, food banks, and church facilities; and ( )

c. Retail markets, meat, fish, delicatessen, bakery and supermarkets, convenience stores, health food stores, and neighborhood markets; and ( )

d. Food, water and beverage processing and bottling facilities that manufacture, process and distribute food, water and beverages within the state of Idaho, and are not inspected for food safety by a federal agency. ( )

04. These Rules Do Not Apply To These Establishments. These rules do not apply to the following establishments as exempted in Idaho Code. ( )

a. Agricultural markets as exempted in Section 39-1602, Idaho Code. ( )

b. Bed-and-breakfast operations that prepare and offer food for breakfast only to guests. The number of guest beds must not exceed ten (10) beds as defined in Section 39-1602, Idaho Code. ( )

c. Day care facilities regulated by Sections 39-1101 through 39-1119, Idaho Code. ( )

d. Licensed outfitters and guides regulated by Sections 36-2101 through 36-2119, Idaho Code. ( )

e. Low-risk food establishments, as exempted in Section 39-1602, Idaho Code, which offer only non-potentially hazardous foods. ( )

f. Non-profit charitable, fraternal, or benevolent organizations that do not prepare or serve food on a

regular basis as exempted in Section 39-1602, Idaho Code. Food is not considered to be served on a regular basis if it is not served for more than five (5) consecutive days or no more than three (3) occasions per year for foods which are not potentially hazardous. For all other food, it must not be served more than one (1) meal per week. ( )

g. Private homes where food is prepared or served for family consumption or receives catered or home-delivered food as exempted by Section 39-1602, Idaho Code. ( )

05. How To Use This Chapter Of Rules. The rules in this chapter are modifications, additions or deletions made to the federal publication incorporated by reference in Section 004 of these rules. In order to follow these rules the publication is required. Changes to those standards are listed in this chapter of rules by listing which section of the publication is being modified at the beginning of each section of rule. ( )

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, the Department has no written interpretations that apply to rules of this chapter. ( )

003. ADMINISTRATIVE APPEALS AND CONTESTED CASES.

01. Administrative Appeals. Administrative appeals including compliance conferences are handled by the regulatory authority. See Sections 860 and 861 of these rules for compliance and revocation issues. ( )

02. Contested Cases. Department contested cases and appeals are governed by provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

004. INCORPORATION BY REFERENCE.
The Department is adopting by reference the "Food Code, 2001 Recommendations of the United States Public Health Service Food and Drug Administration," published by National Technical Information Service, Publication PB2002-100819. A certified copy of this publication may be reviewed at the main office of the Department of Health and Welfare. It is also available online at "http://www.cfsan.fda.gov". This publication is being adopted with modifications and additions as follows: ( )

01. Chapter 1, Purpose And Definitions. Additions and modifications have been made to this chapter. See Sections 100 through 199 of these rules. ( )

02. Chapter 2, Management And Personnel. Modifications have been made to this chapter. See Sections 200 through 299 of these rules. ( )

03. Chapter 3, Food. Modifications have been made to this chapter. See Sections 300 through 399 of these rules. ( )

04. Chapter 4, Equipment, Utensils, And Linens. This chapter has been adopted with no modifications. ( )

05. Chapter 5, Water, Plumbing And Waste. This chapter has been adopted with no modifications. ( )

06. Chapter 6, Physical Facilities. This chapter has been adopted with no modifications. ( )

07. Chapter 7, Poisonous Or Toxic Materials. Modifications have been made in this chapter. See Sections 700 through 799 of these rules. ( )

08. Chapter 8, Compliance And Enforcement. Modifications have been made in this chapter. See Sections 800 through 899 of these rules. ( )

09. Annexes 1 Through 7 Are Excluded. These sections have not been adopted. ( )

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS.

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

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

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

04. Telephone. (208) 334-5500. ( )

05. Internet Website. The Department's Internet website is found at "http://www2.state.id.us/dhw/". ( )

006. CONFIDENTIALITY OF RECORDS.
Any disclosure of information obtained by the Department is subject to the restrictions in Title 9, Chapter 3, Idaho Code. Restrictions contained in Section 39-610, Idaho Code, and the Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records," must also be followed. ( )

01. Contested Hearing And Appeal Records. All contested case hearings are open to the public, unless ordered closed at the discretion of the hearing officer based on compelling circumstances. A party to a hearing must maintain confidentiality of discussions that warrant closing the hearing to the public. ( )

02. Inspection Report. A completed inspection report is a public document and is available for public disclosure to any person who requests the report as provided in Idaho's Public Records Law, Title 9, Chapter 3, Idaho Code. ( )

03. Medical Records. Medical information given to the Department or regulatory authority shall be confidential and must follow IDAPA 16.05.01 "Use And Disclosure Of Department Records". ( )

04. Plans And Specifications. Plans and specifications submitted to the regulatory authority as required in Chapter 8 of the 2001 Food Code referenced in Section 004 of these rules, must be treated as confidential or trade secret information under Section 9-340D, Idaho Code. ( )

007. -- 049. (RESERVED).

050. TRAINING AND INFORMATIONAL MATERIALS.
The Department is authorized under Section 56-1007, Idaho Code, to establish a reasonable charge for training and informational materials that are provided to the public. ( )

051. -- 099. (RESERVED).

100. PURPOSES AND DEFINITIONS.
Sections 100 through 199 of these rules will be used for modifications and additions to Chapter 1 of the 2001 Food Code as incorporated in Section 004 of these rules. ( )

101. -- 109. (RESERVED).

110. DEFINITIONS AND ABBREVIATIONS.
The definitions defined in this section are modifications or additions to the definitions given in the 2001 Food Code. ( )

01. Agricultural Market. Any fixed or mobile retail food establishment engaged in the sale of raw or fresh fruits, vegetables and nuts in the shell. It may also include the sale of factory-sealed non-hazardous foods. ( )

02. **Board**. The State of Idaho Board of Health and Welfare as established in Section 56-1005, Idaho Code. ( )

03. **Consent Order**. A consent order is an enforceable agreement between the regulatory authority and the license holder to correct violations that caused the actions taken by the regulatory authority. ( )

04. **Department**. The Idaho Department of Health and Welfare as established in Section 56-1002, Idaho Code. ( )

05. **Director**. The Director of the Idaho Department of Health and Welfare as established in Section 56-1003, Idaho Code. ( )

06. **Embargo**. An action taken by the regulatory authority that places a food product or equipment used in food production on hold until a determination is made on the product's safety. ( )

07. **Enforcement Inspection**. An inspection conducted by the regulatory authority when compliance with these rules by a food establishment is lacking and violations remain uncorrected after the first follow-up inspection to a routine inspection. ( )

08. **Food Establishment**. Modifications to Section 1-201.10(36) by deleting Section 1-201.10(36)(c)(iii) amends the definition of food establishment. ( )

09. **Food Processing Plant**. Modification to Section 1-201.10(37) by deleting Section 1-201.10(37)(b) amends the definition of food processing plant. ( )

10. **High-Risk Food Establishment**. A high-risk food establishment does the following operations: ( )

a. Extensive handling of raw ingredients; ( )

b. Preparation processes that include the cooking, cooling and reheating of potentially hazardous foods. ( )

c. A variety of processes requiring hot and cold holding of potentially hazardous food. ( )

11. **License**. The term "license" is used in these rules the same as the term "permit" is used in the 2001 Food Code. ( )

12. **License Holder**. The term "license holder" is used in these rules the same as the term "permit holder" is used in the 2001 Food Code. ( )

13. **Low-Risk Food Establishment**. A low-risk food establishment provides factory-sealed pre-packaged non-potentially hazardous foods. The establishment may have limited preparation of non-potentially hazardous foods only. ( )

14. **Medium-Risk Food Establishment**. A medium-risk food establishment includes the following: ( )

a. A limited menu of one (1) or two (2) items; or ( )

b. Pre-packaged raw ingredients cooked or prepared to order; or ( )

c. Raw ingredients requiring minimal assembly; or ( )

d. Most products are cooked or prepared and served immediately; or ( )

e. Hot and cold holding of potentially hazardous foods is restricted to single meal service. ( )

15. **Regulatory Authority**. The Department or its designee is the regulatory authority authorized to enforce compliance of these rules. ( )

a. The Department is responsible for preparing the rules, rule amendments, standards, policy statements, operational procedures, program assessments and guidelines. ( )

b. The seven (7) Public Health Districts and the Bureau of Facility Standards have been designated by the Director as the regulatory authority for the purpose of issuing licenses, collecting fees, conducting inspections, reviewing plans, determining compliance with the rules, investigating complaints and illnesses, examining food, embargoing food and enforcing these rules. ( )

16. **Risk Control Plan**. Is a document describing the specific actions to be taken by the license holder to address and correct a continuing hazard or risk within the food establishment. ( )

111. -- 199. (RESERVED).

200. MANAGEMENT AND PERSONNEL.
Sections 200 through 299 of these rules will be used for modifications and additions to Chapter 2 of the 2001 Food Code as incorporated in Section 004 of these rules. ( )

201. -- 209. (RESERVED).

210. DEMONSTRATION OF KNOWLEDGE.
Modification to Section 2-102.11(A). The person in charge of a food establishment may demonstrate his knowledge on the risks of foodborne illness or health hazards by complying with this code and not having any critical violations at the time of inspection. ( )

211. -- 219. (RESERVED).

220. EMPLOYEE HEALTH.
In addition to Section 2-201.12. The person in charge of a food establishment must notify the regulatory authority to obtain guidance on proper actions needed to protect the public if he has reason to suspect that any employee has a disease that is communicable through food as listed in IDAPA 16.02.10, "Idaho Reportable Diseases," Subsection 025.02. ( )

221. -- 299. (RESERVED).

300. FOOD.
Sections 300 through 399 of these rules will be used for modifications and additions to Chapter 3 of the 2001 Food Code as incorporated in Section 004 of these rules. ( )

301. -- 319. (RESERVED).

320. MEAT AND POULTRY.

01. **Custom Meat**. Meat that is processed for individual owner(s) by a custom butcher, under the custom exemption in 9 CFR 303.1 "Mandatory Meat Inspection Exemptions," must be marked "Not For Sale" and may not be sold, served or given away to any member of the public. This meat must be for the use in the household of such owner(s), their families, non-paying guest and employees only. ( )

02. **Poultry Exemption**. Poultry that is exempt in 9 CFR 381.10, Subpart C "Mandatory Poultry Products Inspection Exemptions" may be sold, served or given away in Idaho, if it is processed in a licensed food processing facility and is labeled "Exempt from USDA Inspection per PL 492". ( )

321. -- 324. (RESERVED).

325. GAME ANIMALS.
Modification to Section 3-201.l7(A)(4), is made by deleting Section 3-201.17(A)(4) and replacing it with Subsections 325.01 through 325.03 of these rules. ( )

01. Field Dressed Game Animals. Uninspected wild game animals and wild poultry may be custom processed or prepared and served upon request by an individual having ownership of the animal, and shall be processed for or served to that owner and for the family or guests of that individual animal owner only. ( )

02. Processing Game Animals. Game animals and birds are to be completely separated from other food during storage, processing, preparation and service with the use of separate equipment or areas or by scheduling and cleaning, providing by compliance with the following: ( )

a. Slaughtering and cleaning of game animals or birds can not be done in the food establishment, except for meat processing establishments with kill floors; and ( )

b. Game animals and other animal carcasses are free of any visible dirt, filth, fecal matter or hair before such carcasses enter the food establishment, except for meat processing establishments with kill floors; and ( )

c. An identifying tag with the owner's name must be on each carcass or divided parts and packaged or wrapped parts; and ( )

d. Each carcass or divided parts and packaged or wrapped parts are marked or tagged with a "Not for sale" label. These may not be sold, given away, or served to any members of the public. ( )

03. Uninspected Game Animals. Any uninspected game animals prepared and served in a food establishment may only be prepared and served at the request of the owner of the animals for the owner and invited family or friends at a private dinner. These animals may not be served, sold, or given away to any members of the public. ( )

326. -- 349. (RESERVED).

350. TEMPERATURE REQUIREMENTS.
Modifications are being made to the temperature guidelines in the following sections of the 2001 Food Code. ( )

01. Specifications For Receiving Potentially Hazardous Food. Modification to Section 3-202.11(D). Food that is cooked to a temperature and for a time specified under Sections 3-401.11 through 3-301.13 and received hot, must be at a temperature of 57°C (135°F) or above. ( )

02. Preventing Contamination From In-Use Utensils, Between Use Storage. Modification to Section 3-304.12(F). In a container of water, if the water is maintained at a temperature of at least 57°C (135°F) and the container is cleaned at a frequency specified under Subparagraph 4-602.11(D)(7). ( )

03. Plant Food Cooking For Hot Holding. Modification to Section 3-401.13. Fruits and vegetables that are cooked for hot holding must be cooked to a temperature of 57°C (135°F). ( )

04. Reheating For Hot Holding Ready To Eat Food. Modification to Section 3-403.11(C). Food taken from a commercially processed hermetically sealed container, or from an intact package from a food processing plant that is inspected by the food regulatory authority that has jurisdiction of the plant, must be heated to a temperature of at least 57°C (135°F) for hot holding. ( )

05. Cooling Cooked Potentially Hazardous Food. Modification to Section 3-501.14(A). Cooked potentially hazardous food must be cooled: ( )

a. Within two (2) hours from 57°C (135°F) to 21°C (70°F); and ( )

b. Within six (6) hours from 57°C (135°F) to 5°C (41°F) or less, or to 7°C (45°F) or less as specified

under 3-501.16(A)(2)(b) provided the food is cooled from 57°C (135°F) to 21°C (70°F) within the first two (2) hours. ( )

06. Potentially Hazardous Food, Hot And Cold Holding. Modification to Section 3-501.16(A)(1). Potentially hazardous food must be maintained at 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified under Section 3-401.11(B) or reheated as specified in Section 3-403.11(E) may be held at a temperature of 54°C (130°F). ( )

351. VARIANCE REQUIREMENTS FOR FOOD ESTABLISHMENTS.
Modifications to Section 3-502.11. Sections 3-502.11(E) and (F), are not adopted. ( )

352. -- 354. (RESERVED).

355. FOOD PROCESSING PLANTS.
Food processing plants, establishments, canning factories or operations must meet the requirements in Chapters 1 through 8 of the 2001 Food Code, and Subsections 355.01 through 355.05 of these rules. ( )

01. Thermal Processing Of Low-Acid Foods. Low-acid food products processed using thermal methods for canning must meet the requirements of 21 CFR 113. ( )

02. Bottled Water Processing. Bottled drinking water processed in Idaho must be from a licensed processing facility that meets the requirements of 21 CFR 129. Bottled drinking water must also meet the quality and monitoring requirements in 21 CFR 165. ( )

03. Approval of Process Methods. A variance by the regulatory authority must be approved and granted for specialized processing methods for products listed in Section 3-502.11. ( )

04. Labels. Proposed labels must be submitted to the regulatory authority for review and approval before printing. ( )

05. Testing. The license holder is responsible for chemical, microbiological or extraneous material testing procedures to identify failures or food contamination of food products being processed or manufactured by the license holder. ( )

06. Quality Assurance Program. The license holder or his designated person must develop and submit to the regulatory authority for review and approval a quality assurance program or HACCP plan which covers the food processing operation. The program must include the following: ( )

a. An organization chart identifying the person responsible for quality control operations; ( )

b. A process flow diagram outlining the processing steps from the receipt of the raw materials to the production and packaging of the finished product(s) or group of related products; ( )

c. A list of specific points in the process which are critical control points that must have scheduled monitoring; ( )

d. Product codes that establish and identify the production date and batch; ( )

e. A manual covering sanitary maintenance of the facility and hygienic practices to be followed by the employees; and ( )

f. A records system allowing for review and evaluation of all operations including the quality assurance program results. These records must be kept for a period of time that exceeds the shelf life of the product by six (6) months or for two (2) years, whichever is less. ( )

356. -- 359. (RESERVED).

360. ADVISING CONSUMERS OF HEALTH RISK OF RAW OR UNDERCOOKED FOODS.
Modification to Section 3-603.11. ( )

01. Consumption Of Animal Foods That Are Raw, Undercooked, Or Not Otherwise Processed To Eliminate Pathogens. Except as specified in Section 3-401.11(C) and Subparagraph 3-401.11(D)(3) and under Section 3-801.11(D), if an animal food such as beef, eggs, fish, lamb, milk, pork, poultry, or shellfish that is raw, undercooked or not otherwise processed to eliminate pathogens is offered in a ready-to-eat form as a deli, menu, vended, or other item; or as a raw ingredient in another ready-to-eat food, the license holder must inform the consumers of health risks. ( )

02. How To Inform Consumers Of Health Risk. The license holder must use any effective means to inform consumers of potential health risks. Some effective ways that may be used to inform consumers are: brochures, deli case placards, signs or verbal warnings, that state, "Consuming raw or undercooked meats, poultry, seafood, shellfish, or eggs may increase your risk of foodborne illness, especially if you have certain medical conditions". ( )

361. -- 369. (RESERVED).

370. ADULTERATED OR MISBRANDED FOOD.
The regulatory authority may order the license holder or other person who has custody of misbranded food to destroy, denature or recondition adulterated or misbranded food according to Section 37-118, Idaho Code. See Section 851 of these rules for embargo, tagging, storage and release of adulterated or misbranded food. ( )

371. -- 699. (RESERVED).

700. POISONOUS OR TOXIC MATERIALS.
Sections 700 through 799 of these rules will be used for modifications and additions to Chapter 7 of the 2001 Food Code as incorporated in Section 004 of these rules. ( )

701. -- 719. (RESERVED).

720. RESTRICTION AND STORAGE OF MEDICINES.
Modifications to Section 7-207.11. ( )

01. Medicines Allowed In A Food Establishment. Only those medicines that are necessary for the health of employees, patients or residents in a care facility are allowed in a food establishment. This section does not apply to medicines that are stored or displayed for retail sale. ( )

02. Labeling Of Medicines. Medicines that are in a food establishment for the employees, patients or residents use must be labeled as specified under Section 7-101.11 and located to prevent the contamination of food, equipment, utensils, linens, and single-service and single-use articles. ( )

721. REFRIGERATED STORAGE OF MEDICINES.
Modification to Section 7-207.12. Medicines belonging to employees, patients or residents in a care facility that requires refrigeration and are stored in a food refrigerator. ( )

01. Medicines Stored In A Leak Proof Container. Medicines must be stored in a package or container and kept inside a covered, leak proof container that is identified as a container for the storage of medicines. ( )

02. Medicines Stored Are Not Accessible. Medicines must be located so they are not accessible to patients or residents in a care facility. ( )

722. -- 799. (RESERVED).

800. COMPLIANCE AND ENFORCEMENT.
Sections 800 through 899 of these rules will be used for modifications and additions to Chapter 8 of the 2001 Food

Code as incorporated in Section 004 of these rules. ( )

801. -- 829. (RESERVED).

830. APPLICATION FOR A LICENSE.

01. To Apply For A Food License. To apply for an Idaho food license the application and fee is submitted to the "regulatory authority" as defined in Section 110 of these rules. ( )

02. Food License Expiration. The license for an Idaho food establishment expires on December 31st of each year. ( )

03. Renewal Of License. A renewal application and a license fee must be submitted to the regulatory authority by December 1st of each year for the next calendar year starting January 1st. ( )

04. Summary Suspension Of License. A license may be immediately suspended under Section 831 of these rules. Reinstatement of a license after a summary suspension does not require a new application or fee unless the license is revoked. ( )

05. Revocation Of License. When corrections have been made to a food establishment whose license has been revoked under Section 860 of these rules, a new application and fee must be submitted to the regulatory authority. ( )

06. License Is Non-Transferable. A license may not be transferred when ownership changes according to Section 8-304.20, of the 2001 Food Code. The new owner must apply for his own license. ( )

831. SUMMARY SUSPENSION OF LICENSE.
The regulatory authority may summarily suspend a license to operate a food establishment when it determines an imminent health hazard exists. ( )

01. Reasons A Summary Suspension May Be Issued. When a food establishment does not follow the principles of food safety, or a foodborne illness is found, or an environmental health hazard exists and public safety cannot be assured by the continued operation of the food establishment, a summary suspension may be issued. The following are some reasons the regulatory authority may determine a summary suspension is necessary: ( )

a. Inspection of the food establishment shows uncorrected critical violations; ( )

b. Examination of food shows the food is unsafe; ( )

c. Review of records shows that proper steps for food safety have not been met; ( )

d. An employee working with food is suspected of having a disease that is communicable through food; or ( )

e. An imminent health hazard exists. ( )

02. Prior Notification Is Not Required For A Summary Suspension. Upon providing a written notice of summary suspension to the license holder or person in charge, the regulatory authority may suspend a food establishment's license without prior warning, notice of hearing, or hearing. ( )

03. Written Notice of Summary Suspension. The regulatory authority must give the license holder or person in charge a written notice when suspending a license. The notice must include the following: ( )

a. The specific reasons or violations the summary suspension is issued for with reference to the specific section of the 2001 Food Code which is in violation; ( )

b. A statement notifying the food establishment its license is suspended and all food operations are to

cease immediately; ( )

c. The name and address of the regulatory authority representative to whom a written request for re-inspection can be made and who can certify the reasons for the suspension have been eliminated; ( )

d. A statement notifying the food establishment of its right to an informal hearing with the regulatory authority upon submission of a written request within fifteen (15) days of receiving the summary suspension notice; and ( )

e. A statement informing the food establishment that proceedings for revocation of its license will be initiated by the regulatory authority, if violations are not corrected. ( )

f. The right to appeal to the Department as provided in Section 861 of these rules. ( )

04. Length Of Summary Suspension. The suspension will remain in effect until the conditions cited in the notice of suspension no longer exist and their elimination has been confirmed by the regulatory authority during a re-inspection. ( )

05. Re-Inspection Of Food Establishment The regulatory authority will conduct a re-inspection of the food establishment within two (2) working days of receiving a written request stating the condition for the suspension no longer exists. ( )

06. Reinstatement Of License. The regulatory authority will immediately reinstate the suspended license if the re-inspection determines the public health hazard no longer exists. The regulatory authority will provide a written notice of reinstatement to the license holder or person in charge. ( )

832. -- 839. (RESERVED).

840. INSPECTIONS AND CORRECTION OF VIOLATIONS.
Modification to Section 8-401.10 . ( )

01. Inspection Interval Section 8-401.10(A). Except as specified in Section 8-401.10(C), the regulatory authority must inspect a food establishment at least once a year. ( )

02. Section 8-401.10(B). This section has not been adopted. ( )

03. Section 8-401.10(C). This section is adopted as published. ( )

841. INSPECTION SCORES.
The regulatory authority must provide the license holder an inspection report with a total score indicating the number of critical item violations and the number of repeat critical violations added together. Repeat violations are those observed during the last inspection. The inspection report will also score the total the number of non-critical violations and the number of repeat non-critical violations. These scores will be used to determine if a follow-up inspection or a written report of correction is needed to verify corrections have been made. ( )

01. Medium-Risk Food Establishment. If the critical violations exceed three (3), or the non-critical violations exceed six (6), an on-site follow-up inspection is required for verification of correction by the regulatory authority. ( )

02. High-Risk Food Establishment. If the critical violations exceed five (5), or the non-critical violations exceed eight (8), an on-site follow-up inspection is required for verification of correction by the regulatory authority. ( )

03. Written Violation Correction Report. A written violation correction report by the license holder may be provided to the regulatory authority if the total inspection score of the food establishment does not exceed those listed in Section 845 of these rules. The report must be mailed within five (5) days of the correction date identified on the inspection report. ( )

842 -- 844. (RESERVED).

845. VERIFICATION AND DOCUMENTATION OF CORRECTION.
In addition to Section 8-405.20 of the 2001 Food Code, the on-site follow-up inspection may not be required for verification of correction if the regulatory authority chooses to accept a written report of correction from the license holder. ( )

01. Written Report Of Correction. The regulatory authority may choose to accept a written report of correction from the license holder stating that specific violations have been corrected. The license holder must submit this report to the regulatory authority within five (5) days after the correction date identified on the inspection report. ( )

a. Medium-Risk Food Establishment. If the critical violations do not exceed three (3), or the non-critical violations do not exceed six (6), a follow-up inspection is not required for verification of correction. ( )

b. High-Risk Food Establishment. If the critical violations do not exceed five (5), or the non-critical violations do not exceed eight (8), a follow-up inspection is not required for verification of correction. ( )

02. Risk Control Plan. The regulatory authority may require the development of a risk control plan as verification of correction. The risk control plan must provide documentation on how the license holder will obtain long term correction of critical violations that are repeated violations, including how control will be monitored and who will be responsible. ( )

846. -- 849. (RESERVED)

850. ENFORCEMENT INSPECTIONS.

01. Follow-Up Inspection. If a follow-up inspection reveals that critical or non-critical violations identified on a previous inspection have not been corrected or still exist, an enforcement inspection may be made. ( )

02. Written Notice. The license holder will receive written notice on the inspection form of the specific date for an enforcement inspection. This date must be within fifteen (15) days of the current or follow-up inspection. ( )

03. Enforcement Inspections On Consent Order. When a compliance conference results in a consent order and includes a compliance schedule to correct violations without further regulatory action, all inspections by the regulatory authority to satisfy the compliance schedule will be considered enforcement inspections until the next annual inspection. ( )

04. Regulatory Action. If the violations have not been corrected by the date of the enforcement inspection, regulatory action will be initiated to revoke the license issued to the food establishment. ( )

851. ENFORCEMENT PROCEDURES FOR ADULTERATED OR MISBRANDED FOOD.
The regulatory authority may order the license holder or other person who has custody of adulterated or misbranded food to destroy, denature or recondition adulterated or misbranded food according to Section 37-118, Idaho Code. The following procedures apply: ( )

01. Serving An Embargo Order. An embargo order must be served by one (1) of the following ways: ( )

a. Delivered personally to the license holder or person in charge of the food establishment; or ( )

b. Posted at a public entrance to the food establishment, provided a copy of the notice is sent by first-class mail to the license holder or the person in charge of the embargoed food. ( )

02. The Embargo Order Is Effective When Served. The embargo order is effective at the time the notice is delivered to the license holder or person in charge, or when the notice is posted. ( )

03. Tagging Embargoed Food. The regulatory authority must securely place an official tag or label on food or containers identified as food subject to the hold order. ( )

04. Storage Of Embargoed Food. The regulatory authority allows storage of food under conditions specified in the embargo order, unless storage is not possible without risk to the public heath. The regulatory authority may order immediate destruction of the adulterated or misbranded food for public safety. ( )

05. Removal Of Embargo Tag Or Label. The removal of the embargo tag, label or other identification from food under embargo must be done by the regulatory authority. ( )

06. Embargo Release. The issue of release and removal of the embargo tag, label or other identification from the suspected food when it is not adulterated or misbranded must be done by the regulatory authority. ( )

852. -- 859. (RESERVED).

860. REVOCATION OF LICENSE.
The regulatory authority may revoke the license issued to a food establishment when the license holder fails to comply with these rules or the operation of the food establishment is a hazard to public health. ( )

01. Reasons A License May Be Revoked. ( )

a. The license holder violates any term or condition in Section 8-304.11 of the 2001 Food Code. ( )

b. Access to the facility is denied or obstructed by an employee, agent, contractor or other representative during the performance of the regulatory authority's duties. It is not necessary for the regulatory authority to seek an inspection order to gain access as permitted in Section 8-402.40 of the 2001 Food Code, before proceeding with revocation. ( )

c. A public health hazard or critical violation remains uncorrected after being identified by the regulatory authority and an enforcement inspection confirms the violation or hazard still exists. See Section 850 of these rules on enforcement inspections. ( )

d. A non-critical violation remains uncorrected after being identified by the regulatory authority and an enforcement inspection confirms the violation still exists. See Section 845 of these rules on verification and documentation of correction. ( )

e. Failure to comply with any consent order issued after a compliance conference. See Section 861 of these rules on compliance conference. ( )

f. Failure to comply with a regulatory authority's summary suspension order. See Section 831 of these rules on summary suspension of a license. ( )

g. Failure to comply with an embargo order. See Section 851 of these rules on adulterated or misbranded food. ( )

h. Failure to comply with a regulatory authority order issued when an employee is suspected of having a communicable disease. See Section 220 of these rules on employee health. ( )

02. Notice To Revoke A License. The regulatory authority must notify the license holder of the food establishment in writing of the intended revocation of the license. See Section 861 of these rules for appeal process. The notice must include the Subsections 860.02.a. through 860.02.c. of these rules: ( )

a. The specific reasons and sections of the Idaho Food Code which are in violation and the cause for the revocation; and ( )

b. The right of the license holder to request in writing a compliance conference with the regulatory authority within fifteen (15) days of the notice; and ( )

c. The right of the license holder to appeal in writing to the Department of Health and Welfare. See Subsection 861.02 of these rules. ( )

d. The following is sufficient notification of the license holder's appeal rights: "You have the right to request in writing a compliance conference with (name and address of designated health district official) within fifteen (15) days of the receipt of this notice. You may also appeal the revocation of your license to the Director of the Department of Health and Welfare by filing a written appeal with the Department as provided in IDAPA 16.05.03, "Rules Governing Contested Case Proceeding and Declaratory Rulings," within fifteen (15) days of the receipt of this notice, or if a timely request is made for a compliance conference and the matter is not resolved by a consent order, within five (5) working days following the conclusion of the compliance conference." ( )

03. Effective Date of Revocation. The revocation will be effective fifteen (15) days following the date of service of notice to the license holder, unless an appeal is filed or a timely request for a compliance conference is made. If a compliance conference is requested and the matter is not resolved by a consent order, the revocation will be effective five (5) working days following the end of the conference, unless an appeal is filed with the Director of the Department of Health and Welfare within that time. See Section 861 of these rules for compliance conference, consent order and appeal process. ( )

861. APPEAL PROCESS.

A license holder may appeal a summary suspension, notice of revocation, other action, or failure to act by the regulatory authority which adversely affects the license holder. A summary suspension or other emergency order is not stayed during the appeal process. ( )

01. Compliance Conference. The license holder may request in writing a compliance conference with the regulatory authority within fifteen (15) days of receipt of the notice or action by the regulatory authority. If a timely request for a compliance conference is made, a compliance conference will be scheduled within twenty (20) days and conducted in an informal manner by the regulatory authority. At the compliance conference the license holder may explain the circumstances of the alleged violations and propose a resolution for the matter. ( )

a. If the compliance conference results in an agreement between the license holder and the regulatory authority to remedy circumstances giving rise to the action and to assure future compliance, the agreement must be put in written form and signed by both parties. This written agreement shall constitute an enforceable consent order. ( )

b. Unless otherwise specifically stated in the consent order, the agreement shall be for the duration of the existing license only. ( )

02. Appeal To The Director. The license holder may appeal in writing to the Director of the Department of Health and Welfare within fifteen (15) days of receipt of the notice of action by the regulatory authority, or if a timely request for a compliance conference was made, within five (5) working days following the completion of the compliance conference. ( )

a. The appeal must be in writing following the procedures in IDAPA 16.05.03 "Rules Governing Contested Case Proceedings and Declaratory Rulings". ( )

b. Procedures on appeal to the Director are governed by IDAPA 16.05.03 "Rules Governing Contested Case Proceedings and Declaratory Rulings". ( )

862. -- 869. (RESERVED).

870. SERVICE OF NOTICE.

01. Service Of Notice. A notice is considered properly served by any individual, or organization authorized to serve a civil process notice in any of the following ways: ( )

a. The notice is personally delivered to the license holder, manager or person in charge of the food establishment. ( )

b. The notice is clearly posted at a public entrance to the food establishment and a copy of the notice is also sent by first-class mail to the license holder. ( )

c. The notice is sent to the license holder's last known address by registered or certified mail, or by other public means in which a written acknowledgement of receipt is acquired. ( )

02. Proof Of Service. Proof of service is determined when the person delivering the notice signs a certificate stating the notice has been served or posted, or by admission of the signed receipt by the license holder or person in charge of the food establishment. ( )

871. -- 889. (RESERVED).

890. CRIMINAL AND CIVIL PROCEEDINGS.
The regulatory authority may choose to enforce the provisions of these rules and its administrative orders through the courts. ( )

01. Criminal Proceedings. Misdemeanor proceedings to enforce these rules, federal regulations, and the enabling statutes may be instituted as provided in Sections 37-117, 37-119, 37-2103, and 56-1008, Idaho Code. These statutes provide for fines or terms of imprisonment that may be sought through the court of competent jurisdiction. ( )

02. Civil Proceedings. Civil enforcement actions may be commenced and prosecuted in the district court in the county where the alleged violation occurred according to Sections 56-1009 and 56-1010, Idaho Code. The person who is alleged to have violated any statute, rule, federal regulation, license or order may be charged in the court proceeding. This action may be brought to compel compliance with these rules, regulations, license or order for relief or remedies authorized in these rules. ( )

03. Injunctive Relief. In addition to other remedies provided by law, Section 56-1009, Idaho Code, allows for a search warrant to gain access and injunctions to be issued in the name of the state against any person or entity to enjoin them from violating these rules, regulations, statutes or administrative orders. ( )

891. -- 999. (RESERVED).

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0201

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 2002.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-201, 56-202(b), 56-203(g), 56-209, 56-209b, and 56-1004(1)(a), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than November 20, 2002.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

2002 Legislation effective July 1, 2002, increased the maximum Temporary Assistance for Families in Idaho (TAFI) payment. The rules are being amended to be sure TAFI income will be counted consistently when Medicaid eligibility is being determined. This will provide eligible households with the same length of Medicaid coverage while ensuring TAFI households entering the working world will receive Transitional Medicaid (TM) services to help continue their efforts toward self-reliance. In addition, rules are being updated to clarify Idaho Code references, financial responsibility and income exclusions.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to confer a benefit for persons eligible to receive TAFI and Medicaid benefits.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes were necessary due to 2002 Legislation.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Phil Gordon, (208) 334-5818.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before November 27, 2002.

DATED this 24th day of September, 2002.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0301-0201

000. LEGAL AUTHORITY.
~~*The Department of Health and Welfare is authorized by*~~ In accordance with Sections 56-201, 56-202(b), 56-203(g), 56-209, 56-209~~(~~b~~)~~, and 56-1004(1)(a), Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules for the administration of the Medicaid program. ~~*(7-1-98)*~~(7-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency has written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. The document is available for public inspection and copying at cost at the Department of Health and Welfare, 450 West State Street, P.O. Box 83720, Boise, Idaho, 83720-0036 or at any of the Department's Regional Offices.
~~*(7-1-98)*~~(7-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

005. ABBREVIATIONS.
Abbreviations applicable to IDAPA 16.03.01 are listed in Subsections 005.01 through 005.3~~3~~7 of these rules.
~~*(7-1-98)*~~(7-1-02)T

01. AFDC. Aid to Families with Dependent Children, the cash assistance program for families and children in effect through June 30, 1997. (7-1-98)

02. AG. Office of the Attorney General, Health and Welfare Division. (7-1-98)

03. AIM. The Department's Advanced Information Management system for Medicaid. (7-1-98)

04. ASVI. Alien Status Verification Index. (7-1-98)

05. BCSS. Bureau of Child Support Services. (7-1-98)

06. CHIP. Child Health Insurance Program. (7-1-99)

07. DHW. Department of Health and Welfare. (7-1-98)

08. DOL. Department of Labor. (7-1-99)

09. DVR. Department of Vocational Rehabilitation. (7-1-98)

10. EE. Eligibility Examiner. (7-1-98)

11. EITC. Earned Income Tax Credit. (7-1-98)

12. EPICS. The DHW Eligibility Programs Integrated Computer System. (7-1-98)

13. EPSDT. Early and Periodic Screening, Diagnosis, and Treatment. (7-1-98)

14. **FmHA**. The Farmer's Home Administration of the U.S. Department of Agriculture. (7-1-98)

15. **FPG**. Federal Poverty Guideline. (7-1-98)

16. **HUD**. The U.S. Department of Housing and Urban Development. (7-1-98)

17. **ICF/MR**. Intermediate Care Facility/Mentally Retarded. (7-1-98)

18. **ICSES**. The Idaho Child Support Enforcement System. (7-1-98)

19. **IEVS**. Income and Eligibility Verification System. (7-1-98)

20. **INA**. Immigration and Naturalization Act. (7-1-98)

21. **IRS**. Internal Revenue Service. (7-1-98)

22. **MA**. Medicaid (Medical Assistance). (7-1-98)

23. **PRWORA**. Personal Responsibility Work Opportunity Reconciliation Act of 1996. (7-1-98)

24. **PWE**. Principal Wage Earner. (7-1-99)

25. **RSDI**. Retirement, Survivors, and Disability Insurance. (7-1-98)

26. **SAVE**. Systematic Alien Verification for Entitlement. (7-1-98)

27. **SRS**. Self Reliance Specialist. (7-1-98)

28. **SSA**. Social Security Administration. (7-1-98)

29. **SSI**. Supplemental Security Income. (7-1-98)

30. **SSN**. Social Security Number. (7-1-98)

31. **TAFI**. Temporary Assistance for Families in Idaho. (7-1-98)

32. **TANF**. Temporary Assistance to Needy Families. (7-1-02)T

3~~2~~3. **TPL**. Third Party Liability. (7-1-98)

34. **TM**. Transitional Medicaid. (7-1-02)T

3~~3~~5. **UIB**. Unemployment Insurance Benefits. (7-1-98)

3~~4~~6. **VA**. Veterans Administration. (7-1-98)

3~~5~~7. **VRS**. Vocational Rehabilitation Services, Department of Education. (7-1-98)

(BREAK IN CONTINUITY OF SECTIONS)

204. CITIZENSHIP AND LEGAL NON-CITIZEN REQUIREMENT.
Individuals must be U.S. citizens or nationals or qualified legal non-citizens. Nationals of American Samoa or Swain's Island are the equivalent of U.S. citizens. Only groups of legal non-citizens listed in Subsections ~~10~~204.01 through ~~10~~204.09 of this rule may be eligible. ~~(7-1-99)~~(7-1-02)T

01. Permanent Residents Admitted Before August 22, 1996. Participants must be: (7-1-99)

a. Legal non-citizens lawfully admitted for permanent residence. (7-1-99)

b. American Indians born in Canada to whom Section 289 of the INA applies or legal non-citizens who are members of Indian tribes. (7-1-99)

02. Permanent Residents Admitted On Or After August 22, 1996. A lawful permanent resident admitted on or after August 22, 1996: (7-1-99)

a. Who is a veteran honorably discharged for a reason other than alienage or is on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or (7-1-99)

b. Who has lived in the U.S. for five (5) years and has forty (40) quarters of work. (7-1-99)

03. Refugees. A refugee admitted under Section 207 of the INA, a Cuban/Haitian entrant as defined in Section 501(e) of the Refugee Assistance Act of 1980, or an Amerasian admitted under Section 584 of Public Law 100-202 and amended by Public Law 100-461 is eligible: (7-1-99)

a. For seven (7) years from the date of entry; or (7-1-99)

b. With no time limit if the refugee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

04. Asylees. An asylee admitted under Section 208 of the INA is eligible: (7-1-99)

a. For seven (7) years from the date asylee status is assigned; or (7-1-99)

b. With no time limit if the asylee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

05. Deportation Withheld. An individual whose deportation has been withheld under Section 241(b)(3) or 243(h) of the INA is eligible: (7-1-99)

a. For seven (7) years from the date deportation was withheld; or (7-1-99)

b. With no time limit if the deportee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

06. Conditional Entrants. A conditional entrant admitted under Section 203(a)(7) of the INA who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

07. Parolees. A person paroled into the U.S. under Section 212(d)(5) of the INA for a period of at least one (1) year, who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

08. Battered Non-Citizen Admitted Before August 22, 1996. A legal non-citizen admitted to the U.S. before August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A) or 204(a)(1)(B) of the INA, as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA and is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or

unmarried dependent of the veteran or person on active duty. (7-1-99)

09. Battered Non-Citizen Admitted On Or After August 22, 1996. A legal non-citizen admitted to the U.S. on or after August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A) or 204(a)(1)(B) of the INA, or as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA, who is: (7-1-99)

a. A veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or (7-1-99)

b. Who has lived in the U.S. for five (5) years. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

300. FINANCIAL ELIGIBILITY.
Financial eligibility is determined using Section 300 through Section ~~38~~706 of these rules. Income disregards described in Sections 357 through 361 and in Section 38~~6~~8 of these rules do not apply to the Children's Health Insurance Program (CHIP) coverage group. ~~*(3-30-01)*~~(7-1-02)T

301. FINANCIAL RESPONSIBILITY.
The income and resources of individuals who are financially responsible for the Medicaid participant are counted in determining eligibility. Individuals are financially responsible for themselves. Parents are financially responsible for their adoptive and natural children but not step children. Spouses are financially responsible for each other. ~~*(7-1-98)*~~(7-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

303. PERSONS WHO MUST BE INCLUDED IN AN AFDC-RELATED MEDICAID BUDGET UNIT.
Persons in the home listed in Subsections 303.01 through 303.05 must be included in an AFDC-related budget unit. (3-30-01)

01. Parents. A natural or adoptive parent must be included in the budget unit. Both parents must be included if: (4-5-00)

a. One (1) or both parents is incapacitated; (4-5-00)

b. One (1) parent is receiving AABD Medicaid based on the Community Property method and is not an SSI recipient; or (4-5-00)

c. One (1) or both parents is unemployed or underemployed. (3-30-01)

02. Disqualified Parents. Disqualified parents are members of the budget unit, but are not included in the family size. A disqualified parent's income and resources are counted in full. A person is disqualified if: ~~*(4-5-00)*~~(7-1-02)T

a. He does not meet the financial eligibility criteria found in Sections 300 through 706 of these rules; or (7-1-02)T

b. He does not meet the non-financial eligibility criteria found in Sections 200 through 214 of these rules; or (7-1-02)T

c. He fails to cooperate with Medicaid requirements found in Sections 215 through 220 of these rules.

(7-1-02)T

03. **Siblings**. A child's natural or adoptive brother or sister, including half (1/2) siblings, must be included in the budget unit. (4-5-00)

04. **Pregnant Woman With No Other Children**. A pregnant woman, who does not have a child residing in the home, may receive Medicaid. (4-5-00)

a. The needs, income and resources of all persons in the home, who would be included in the budget unit if the child was born, must be counted for Medicaid eligibility. (4-5-00)

b. The father of the child, if living in the home, must be included in the budget unit if the couple is married. The father is not eligible for Medicaid until the child is born. (4-5-00)

05. **Stepparent Incapacitated Or Unemployed**. A stepparent, who lives in the home and has a child in common with the parent, must be included in the budget unit if he is unemployed, or has a physical or mental incapacity expected to last at least thirty (30) days. (3-30-01)

(BREAK IN CONTINUITY OF SECTIONS)

361. DEPENDENT CARE DISREGARD.
A dependent care disregard is subtracted from earnings for dependents requiring care because of employment related reasons. Dependents can be either children or an incapacitated spouse. The amount disregarded is the anticipated cost of care or the maximum care allowance, whichever is less. Maximum dependent care allowances are listed in Subsections 361.01 and 361.02 of this rule. ~~*(3-30-01)*~~(7-1-02)T

01. **Dependents Two Years Of Age Or Older**. Dependents, two (2) years of age or older. ~~*has*~~ have up to one hundred seventy-five dollars ($175) disregarded when the caretaker relative works full-time, eighty (80) or more hours in a month. When the caretaker relative works part-time, less than eighty (80) hours in a month, up to one hundred fifteen dollars ($115) is disregarded. ~~*(7-1-98)*~~(7-1-02)T

02. **Dependents Under Two Years Of Age**. Dependents under two (2) years of age have up to two hundred dollars ($200) disregarded when the caretaker relative works full-time, eighty (80) or more hours per month. When the caretaker relative works part-time, less than eighty (80) hours in a month, up to one hundred thirty-five dollars ($135) is disregarded. (7-1-98)

362. -- 369. (RESERVED).

370. UNEARNED INCOME.
Unearned income includes payments from pensions, RSDI, unemployment compensation, worker's compensation, veteran's benefits, other government benefits, TAFI, TANF, contributions, support payments, and ~~*money*~~ cash gifts. Unearned income includes capital investment returns, such as dividends and interest, or other income not gained through employment. ~~*(7-1-98)*~~(7-1-02)T

371. SUPPORT INCOME.
Support income is any payment an absent parent or absent spouse makes to the family. The payment is support when either parent defines it as such, or when the payment is used to meet the family's needs. A child support payment is unearned income to the child. The first fifty dollars ($50) of child support received for each child is disregarded.
~~*(7-1-98)*~~(7-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

380. RETIREMENT ACCOUNT WITHDRAWALS.
Monthly withdrawals from retirement accounts are unearned income. Principal withdrawn in one (1) lump sum is a resource. Interest from a retirement account withdrawn in one (1) lump sum is unearned income. ~~(7-1-99)~~(7-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

382. EDUCATIONAL INCOME.
Monies obtained for purposes of education are earned or unearned income as listed in Subsections 382.01 through 382.05. Any student financial assistance provided under Title IV of the Higher Education Act or under Bureau of Indian Affairs education program is excluded. ~~(7-1-98)~~(7-1-02)T

01. Carl D. Perkins Vocational And Applied Technology Education Act. Any money in excess of attendance costs is unearned income prorated over the period the grant. (7-1-98)

02. State Work Study Income Of Student. Work Study income, partially or wholly funded through the State, is earned income. (7-1-98)

03. VA Educational Assistance. VA Educational Assistance payments are unearned income. (7-1-98)

04. AmeriCorps. The AmeriCorps living allowance or stipend is earned income. (7-1-98)

05. Federal Or Nonfederal Supported Sources. Individuals may receive scholarships, grants, or awards from state sources, civic, fraternal and alumnus organizations, relatives, or other individuals. The amount of the award, minus costs of attendance, is unearned income prorated over the period of the award. (7-1-98)

(BREAK IN CONTINUITY OF SECTIONS)

385. INCOME EXCLUDED BY FEDERAL LAW.
Income excluded by federal law is not counted in determining income available to the participant. The following kinds of income are excluded by federal law: ~~(7-1-98)~~(7-1-02)T

01. Agent Orange Settlement Funds. Payments made to veterans from the Agent Orange Settlement Fund. (7-1-02)T

02. Alaska Native Claims. Tax-exempt portions of payments made in accordance with the Alaska Native Claims Settlement Act, PL 92-203. Cash, including cash dividend on stock, received from a Native Corporation unless the amount exceeds two thousand dollars ($2,000) per individual, per year. (7-1-02)T

03. AmeriCorps. AmeriCorps payments, other than stipends or living allowances, are excluded. These payments are made for child care allowances and educational awards. (7-1-02)T

04. Child Nutrition Benefits. The value of supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the food service program for children under the National School Fund Act, as amended, (PL 92-433 and PL 93-150). These are the WIC program and school lunch program. (7-1-02)T

05. Commodities And Food Stamps. The value of U.S. Department of Agriculture donated commodities and Food Stamps. (7-1-02)T

06. Disaster Relief. Assistance paid under the Disaster Relief Act of 1974 and aid provided under any federal statute for a President-declared disaster and comparable disaster assistance provided by states, local government and disaster assistance organizations. (7-1-02)T

07. **Elderly Nutritional Benefits**. Any benefits received under Title VII, Nutritional Program for the Elderly, of the Older Americans Act of 1965. (7-1-02)T

08. **Foster Care/Adoption Assistance Payment**. Foster care payments paid by the Department are excluded. Adoption Assistance payments paid by federal, state or local agencies are excluded. (7-1-02)T

09. **Garnishments**. Income garnished by court order is not available. (7-1-02)T

10. **Home Energy Assistance**. PL 100-203 excludes Home Energy Assistance. The aid must be provided based on need certified by the Department. (7-1-02)T

11. **Home Produce**. The value of home produce used by the family. (7-1-02)T

12. **Housing Subsidies**. The value of government rent and/or housing subsidies. (7-1-02)T

13. **HUD Family Self-Sufficiency Escrow Account**. Interest earned on an escrow account established by HUD for families participating in the Family Self-Sufficiency Program established by Section 544 of the National Affordable Housing Act. (7-1-02)T

14. **Income Tax Refunds And EITC Payments**. Income tax refunds are excluded from income, but counted as a resource. Earned Income Tax Credit (EITC) payments, or the advance payment of the EITC, is excluded. (7-1-02)T

15. **Indian Payments**. Payments distributed to or held in trust for members of any Indian tribe issued under Public Law (PL) 92-254, PL 93-134, or PL 94-540. Payments distributed to certain Indian tribes, including the Shoshone Bannock Tribe of Fort Hall, Idaho, referenced under Section 5 of PL 94-114, effective October 10, 1975. Per capita judgment funds paid to members of the Blackfoot Tribe of the Blackfoot Indian Reservation, Montana and the Gros Ventre Tribe of the Fort Belknap Reservation, Montana. Per capita funds held in trust by the Secretary of the Interior for tribal members paid under PL 98-64. Effective January 1, 1994, up to two thousand dollars ($2,000) of payments derived from interests of individual Indians in trust or restricted lands are excluded by Section 8 of the PL 93-134 as amended by PL 103-66. (7-1-02)T

16. **Loans**. A bona fide loan is not available income. (7-1-02)T

17. **Low Income Energy Assistance**. Money paid to families under the Low Income Energy Assistance Act of 1981 is excluded. (7-1-02)T

18. **Radiation Exposure Compensation Act**. Payments made to individuals under this act are excluded. (7-1-02)T

19. **Relocation Assistance**. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and relocation payments paid to civilians of World War II per Public Law 100-383. (7-1-02)T

20. **SSI Income Or AABD Income**. Income and resources of a person who has been determined eligible for or is receiving SSI or AABD is excluded. (7-1-02)T

21. **Senior Volunteer Programs**. Payments for supportive services or out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title II and Title III of the Domestic Volunteer Service Act of 1973, Section 418, PL 93-113. (7-1-02)T

22. **Spina Bifida**. Spina bifida allowances paid to children of Vietnam veterans. (7-1-02)T

23. **Third Party Deposits To A Checking Account**. Third party deposits to a participant's checking account are excluded if the deposit is solely for the use of the third party and the participant receives no benefit from the deposit. (7-1-02)T

24. **Title IV Educational Income**. Any student financial assistance provided under Title IV of the Higher Education Act or under Bureau of Indian Affairs education program. (7-1-02)T

25. **Utility Reimbursement Payments**. Utility reimbursement payments made to persons living in housing subsidized by HUD. (7-1-02)T

26. **VISTA Volunteers**. Payments to individual volunteers under PL 96-143, the Domestic Volunteer Act of 1979, under Title I of PL 93-113 pursuant to Section 404(g), which governs the Volunteers in Service to America (VISTA). (7-1-02)T

27. **Work-Related Payments**. Payments made by an employer for work-related expenses are excluded. Work-related expenses include travel and per diem. (7-1-02)T

386. COUNTING TEMPORARY ASSISTANCE TO FAMILIES IN IDAHO (TAFI) INCOME.
Individuals and families are eligible for Medicaid coverage under the Low Income Families With Children group (MA or MU) as described in Section 413 of these rules, if: (7-1-02)T

01. **TAFI Income**. Their only income is Idaho TAFI. (7-1-02)T

02. **TAFI Income And Unearned Income**. Their only income is a combination of Idaho TAFI and other unearned income, but whose total income is equal to or less than the current Idaho TAFI maximum grant amount. (7-1-02)T

03. **TAFI Income And Medicaid Eligible**. Their income includes Idaho TAFI and they meet the Medicaid financial eligibility criteria described in Sections 346 through 388 of these rules. (7-1-02)T

387. COUNTING OUT-OF-STATE TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BENEFITS.
When determining eligibility for Medicaid coverage, TANF payments received from other states are countable unearned income. (7-1-02)T

386~~8~~. ~~*UNEARNED*~~ CHILD SUPPORT INCOME DISREGARD~~*S*~~.
~~*Unearned income disregards are subtracted from monthly income as listed in Subsections 386.01 and 386.02.*~~ The first fifty dollars ($50) of child support received for each child is disregarded. ~~*(7-1-98)*~~(7-1-02)T

~~***01. Child Support Disregard**. The first fifty dollars ($50) of child support is disregarded. (7-1-98)*~~

~~***02. TAFI**. One hundred dollars ($100) of TAFI income is disregarded for one (1) and two (2) person families. One-time only TAFI diversion payments are excluded as income. (3-30-01)*~~

38~~7~~9. -- 399. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

413. LOW INCOME FAMILIES WITH CHILDREN.
Families with minor children in the home, who would be AFDC eligible if the program was in effect, are eligible if non-financial, financial, and the conditions listed in Subsections 413.01 through 413.04 of these rules are met. ~~*(7-1-98)*~~(7-1-02)T

01. **Living With A Relative**. A child must live in a home with an adult caretaker who is related to the child by blood, marriage, or adoption. (7-1-98)

02. **Dependent Child**. A dependent child is a child under eighteen (18) years of age or, if over eighteen

(18) years of age, is expected to graduate from high school by the nineteenth (19th) birthday. (7-1-98)

03. **Financial Deprivation**. ~~*The dependent child must be deprived. Deprivation is the lack of, or interruption in parental care, guidance and support ordinarily received from one (1) or both parents.*~~ A child is financially deprived when ~~*one (1) of the conditions listed in Subsections 413.03.a. through 413.03.d. exists*~~ the family's income does not exceed the income limit for their family size as described in Section 401 of this rule. ~~*(3-30-01)*~~(7-1-02)T

~~***a.*** *Continued Absence. A child is deprived when a parent is continuously absent from the home and no longer provides support, care or parental guidance. This may be due to death, divorce, desertion, marital separation, annulment, deportation or confinement in an institution for more than thirty (30) days. A child is not deprived when the sole reason for the parent's absence is employment away from home. A child is not deprived when the sole reason for a parent's absence is active duty in a uniformed service.* *(3-30-01)*~~

~~***b.*** *Paternity Not Established. A child is deprived when paternity is not established or an Acknowledgement of Paternity form is not signed.* *(3-30-01)*~~

~~***c.*** *Incapacity. A child is deprived when a parent has a physical or mental incapacity expected to last for at least thirty (30) days. A parent is incapacitated when qualified for SSI, AABD, or Social Security Disability. A parent is incapacitated when physically or mentally unable to work full time at his usual occupation, or the occupation for which he was trained, or is unable to perform homemaking activities without help from others.* *(3-30-01)*~~

~~***d.*** *Unemployment or Underemployment. A child is deprived in a two (2) parent family when the family meets financial requirements. The budget unit must include at least one (1) child common to both parents.* *(3-30-01)*~~

04. **One Hundred Eighty-Five Percent Test**. The family is ineligible for AFDC-related Medicaid when total gross income exceeds one hundred eighty-five percent (185%) of the monthly need standard. (3-30-01)

(BREAK IN CONTINUITY OF SECTIONS)

416. TRANSITIONAL MEDICAID (TM).
Individuals and families who were eligible for Medicaid coverage under the Low Income Families with Children group (MA or MU) are eligible for Transitional Medicaid (TM) if the family income exceeds limits because of a reason listed in Subsections 416.01 through 416.03 of this rule. ~~*The caretaker must have earnings each month.*~~ The family must have received Medicaid in three (3) of the six (6) months before the month they became ineligible unless the family meets the condition in Subsection 416.01 of this rule. Eligible families may get TM for up to twelve (12) months. ~~*(4-5-00)*~~(7-1-02)T

01. ~~***Hours Of Employment Increased****. Family income exceeds limits because the caretaker relative's hours of employment increased.*~~ **Idaho TAFI Income And Income From Employment**. Family income exceeds limits because they have Idaho TAFI income and income from employment. ~~*(4-5-00)*~~(7-1-02)T

02. **Employment Income Increased**. Family income exceeds limits because employment income increased. (4-5-00)

03. **Disregard Expired**. Family income exceeds limits because the thirty dollar ($30) plus one-third (1/3) or the thirty dollar ($30) disregard expired. (4-5-00)

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0201

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-201, 56-202, 56-203, 56-209, 56-209b, and 56-1004, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the November 6, 2002, Administrative Bulletin, Volume 02-11, pages 26 through 35.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Phil Gordon, (208) 334-5818.

DATED this 10th day of December, 2002.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
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IDAPA 16, TITLE 03, Chapter 01

RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 02-11, November 6, 2002, pages 26 through 35.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0301

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is April 1, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section 56-1004(1), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The temporary rule and the pending rule are being amended to address comments that were received during the public comment period of the proposed rulemaking. The Department is deleting the Subsection 204.07 because it may not require legal permanent residents to have forty (40) quarters of work to be eligible for benefits.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes different from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the August Administrative Bulletin, Volume 03-8, pages 54 through 57.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Tiffany Kinzler at (208) 334-6540.

DATED this 29th day of September, 2003.

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IDAPA 16, TITLE 03, CHAPTER 01

RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-8, August 6, 2003, pages 54 through 57.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET 16-0301-0301

SUBSECTIONS 204.07 through 204.11 (Partial Section)

204. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible, an individual must be a member of one (1) of the groups listed in Subsections 204.01 through 204.1~~2~~*1* of this rule. ~~*(4-1-03)T*~~*(4-1-03)T*

~~***07. Legal Permanent Resident (LPR) Entering On Or After August 22, 1996****. A legal permanent resident (LPR) entering the U.S. on or after August 22, 1996, who has been living in the U.S. for five (5) years, and has forty (40) quarters of countable work; or*** ~~*(4-1-03)T*~~

0~~*8*~~7. Qualified Non-Citizen Entering On Or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has had a qualified non-citizen status for at least five (5) years; or (4-1-03)T

0~~*9*~~8. American Indian Born In Canada. An American Indian born in Canada under 8 U.S.C. 1359; or (4-1-03)T

~~*1*~~09. American Indian Born Outside The U.S. An American Indian born outside of the U.S., and is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e); or (4-1-03)T

1~~*1*~~0. Qualified Non-Citizen Child Receiving Federal Foster Care. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance; or (4-1-03)T

1~~*2*~~1. Victim Of Severe Form Of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (4-1-03)T

a. Is under the age of eighteen (18) years; or (4-1-03)T

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (4-1-03)T

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied, or (4-1-03)T

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (4-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective April 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-1004(l), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 20, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Sections 204 and 205 are being deleted with both sections being rewritten. Section 204 will clarify and extend eligibility for Medicaid for Families and Children for citizens and qualified non-citizens in compliance with federal law according to 8 U.S.C. 1641(c). Section 205 will clarify that individuals not meeting the citizenship or qualified non-citizen requirements, when all other conditions are met, may be eligible for medical services.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with federal regulations.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are being made due to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Tiffany Kinzler at (208) 334-6540.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before August 27, 2003.

DATED this 23rd day of June, 2003.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0301-0301

~~***204. CITIZENSHIP AND LEGAL NON-CITIZEN REQUIREMENT.***~~
~~*Individuals must be U.S. citizens or nationals or qualified legal non-citizens. Nationals of American Samoa or Swain's Island are the equivalent of U.S. citizens. Only groups of legal non-citizens listed in Subsections 204.01 through 204.09 of this rule may be eligible.* *(7-1-02)T*~~

~~***01. Permanent Residents Admitted Before August 22, 1996****. Participants must be:* *(7-1-99)*~~

~~***a.*** *Legal non-citizens lawfully admitted for permanent residence.* *(7-1-99)*~~

~~***b.*** *American Indians born in Canada to whom Section 289 of the INA applies or legal non-citizens who are members of Indian tribes.* *(7-1-99)*~~

~~***02. Permanent Residents Admitted On Or After August 22, 1996****. A lawful permanent resident admitted on or after August 22, 1996:* *(7-1-99)*~~

~~***a.*** *Who is a veteran honorably discharged for a reason other than alienage or is on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or* *(7-1-99)*~~

~~***b.*** *Who has lived in the U.S. for five (5) years and has forty (40) quarters of work.* *(7-1-99)*~~

~~***03. Refugees****. A refugee admitted under Section 207 of the INA, a Cuban/Haitian entrant as defined in Section 501(e) of the Refugee Assistance Act of 1980, or an Amerasian admitted under Section 584 of Public Law 100-202 and amended by Public Law 100-461 is eligible:* *(7-1-99)*~~

~~***a.*** *For seven (7) years from the date of entry; or* *(7-1-99)*~~

~~***b.*** *With no time limit if the refugee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***04. Asylees****. An asylee admitted under Section 208 of the INA is eligible:* *(7-1-99)*~~

~~***a.*** *For seven (7) years from the date asylee status is assigned; or* *(7-1-99)*~~

~~***b.*** *With no time limit if the asylee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***05. Deportation Withheld****. An individual whose deportation has been withheld under Section 241(b)(3) or 243(h) of the INA is eligible:* *(7-1-99)*~~

~~***a.*** *For seven (7) years from the date deportation was withheld; or* *(7-1-99)*~~

~~***b.*** *With no time limit if the deportee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***06. Conditional Entrants****. A conditional entrant admitted under Section 203(a)(7) of the INA who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***07. Parolees****. A person paroled into the U.S. under Section 212(d)(5) of the INA for a period of at least*~~

~~*one (1) year, who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***08.*** ***Battered Non-Citizen Admitted Before August 22, 1996****. A legal non-citizen admitted to the U.S. before August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A) or 204(a)(1)(B) of the INA, as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA and is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***09.*** ***Battered Non-Citizen Admitted On Or After August 22, 1996****. A legal non-citizen admitted to the U.S. on or after August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A) or 204(a)(1)(B) of the INA, or as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA, who is:* *(7-1-99)*~~

~~***a.*** *A veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or* *(7-1-99)*~~

~~***b.*** *Who has lived in the U.S. for five (5) years.* *(7-1-99)*~~

204. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible, an individual must be a member of one (1) of the groups listed in Subsections 204.01 through 204.12 of this rule. (4-1-03)T

01. U.S. Citizen. A U.S. Citizen; or (4-1-03)T

02. U.S. National, National Of American Samoa Or Swains Island. A U. S. National, National of American Samoa or Swains Island; or (4-1-03)T

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member; or (4-1-03)T

04. Veteran Of The U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran; or (4-1-03)T

05. Non-Citizen Entering The U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, and is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c); or (4-1-03)T

06. Non-Citizen Entering On Or After August 22, 1996. A non-citizen who entered on or after August 22, 1996, and (4-1-03)T

a. Is a refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from their date of entry; or (4-1-03)T

b. Is an asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date their asylee status is assigned; or (4-1-03)T

c. Is an individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date their deportation or removal was withheld; or (4-1-03)T

d. Is an Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be

eligible for seven (7) years from the date of entry; or (4-1-03)T

e. Is a Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act, and can be eligible for seven (7) years from their date of entry; or (4-1-03)T

07. Legal Permanent Resident (LPR) Entering On Or After August 22, 1996. A legal permanent resident (LPR) entering the U.S. on or after August 22, 1996, who has been living in the U.S. for five (5) years, and has forty (40) quarters of countable work; or (4-1-03)T

08. Qualified Non-Citizen Entering On Or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has had a qualified non-citizen status for at least five (5) years; or (4-1-03)T

09. American Indian Born In Canada. An American Indian born in Canada under 8 U.S.C. 1359; or (4-1-03)T

10. American Indian Born Outside The U.S. An American Indian born outside of the U.S., and is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e); or (4-1-03)T

11. Qualified Non-Citizen Child Receiving Federal Foster Care. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance; or (4-1-03)T

12. Victim Of Severe Form Of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (4-1-03)T

a. Is under the age of eighteen (18) years; or (4-1-03)T

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (4-1-03)T

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied, or (4-1-03)T

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (4-1-03)T

~~***205. LEGAL NON-CITIZENS ENTERING THE U.S. ON OR AFTER AUGUST 22, 1996.***~~
~~*Legal non-citizens, not described in Section 204, who enter the U.S. on or after August 22, 1996, are prohibited from receiving Medicaid for five (5) years from the date of entry. The individual, if otherwise eligible, can get services for an emergency condition.* *(7-1-98)*~~

205. INDIVIDUALS NOT MEETING THE CITIZENSHIP OR QUALIFIED NON-CITIZEN REQUIREMENTS.
Individuals who do not meet the citizenship or qualified non-citizen requirements in Section 204 of these rules, may be eligible for emergency medical services if they meet all other conditions of eligibility. (4-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0302

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is July 1, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section 56-1004(1), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The temporary rule effective date for Sections 346 through 349 was misprinted and the effective date of these rules should be July 1, 2003 as stated in the original notice. The text is not being amended, only the effective date is being changed. The original text of the proposed rules was published in the October 1, 2003 Administrative Bulletin, Volume 03-10, pages 226 through 229.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Tiffany Kinzler at (208) 334-6540.

DATED this 23rd day of October, 2003.

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IDAPA 16, TITLE 03, CHAPTER 01

RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN

There are substantive changes from the proposed rule text.

**Sections 346 through 349 have changes in the effective date,
the correct effective date is July 1, 2003.**

**The text of the proposed rule was published in the Idaho Administrative
Bulletin, Volume 03-10, October 1, 2003, pages 226 through 229.**

**This rule has been adopted as a pending rule by the Agency and is now pending
review and approval by the 2004 Idaho State Legislature as a final rule.**

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0302

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-1004(l), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Section 214 is being amended to clarify the Social Security Number (SSN) requirements to align with the federal requirements that the SSN must be verified before an applicant is eligible for Medicaid benefits. Sections 346 through 349 are being amended to clarify how income is calculated and to ensure the income methodology is applied equitably throughout the state.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with federal regulations.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are being made due to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Tiffany Kinzler at (208) 334-6540.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 22, 2003.

DATED this 6th day of August, 2003.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0301-0302

214. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.
An *participant* applicant must provide *a* his Social Security Number (SSN), or proof he has applied for an *Social Security Number* SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. The SSN must be verified by the Social Security Administration (SSA) electronically. *This SSN requirement only applies to persons applying for or receiving Medicaid. A person not applying for or receiving Medicaid does not have to provide an SSN.* When an SSN is unverified, the applicant is not eligible for Medicaid benefits. The Department must notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. *(3-30-01)*(7-1-03)T

01. Application For SSN. The applicant must apply for an SSN, or a duplicate SSN when he cannot provide his SSN to the Department. If the SSN has been applied for but not issued by the SSA, the Department can not deny, delay or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. (7-1-03)T

02. Failure To Apply For SSN. The applicant may be granted good cause for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: (7-1-03)T

a. Is a member of a recognized religious sect or division of the sect; and (7-1-03)T

b. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number. (7-1-03)T

03. SSN Requirement Waived. An applicant may have the SSN requirement waived when he is: (7-1-03)T

a. Only eligible for emergency medical services as described Section 602 of these rules; or (7-1-03)T

b. A waived newborn child as described in Section 601 of these rules. (7-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

346. *DETERMINING INCOME ELIGIBILITY FOR THE MONTH OF APPLICATION* INCOME AVAILABLE TO THE APPLICANT.
Calculate the household's countable income for the application month, and compare the income against the income limits for the appropriate Medicaid program. Use actual income for each of the three (3) retroactive months to determine eligibility for that month. Determine eligibility for each retroactive month separately. Income to the applicant and financially responsible household members must be counted to determine Medicaid eligibility. The income must be under the control of the applicant or financially responsible person during the month(s) for which Medicaid eligibility is being determined. When income is available, the amount will be used to determine eligibility even if the individual chooses not to obtain or use it. The applicant or financially responsible person must take all steps necessary to obtain benefits for which they may be eligible before Medicaid may be approved, including Title II Social Security income (RSDI), unemployment insurance, and worker's compensation. *(3-30-01)*(4-1-03)T

347. *ANTICIPATING* INCOME ELIGIBILITY.
Anticipate income to determine continuing eligibility. Compare the household's countable anticipated income against the income limits for the appropriate Medicaid program. The applicant's countable income must be calculated according to Section 301 of these rules. Actual income already received and income that can reasonably be expected or anticipated is included when calculating income. *(3-30-01)*(4-1-03)T

01. **Income For Children**. Income for children applying for a twelve (12) month continuous eligibility period must be calculated as an annual amount. To be eligible the applicant's countable income must be equal to or less than the annual income limit for the appropriate Medicaid program. (4-1-03)T

02. **Income For Other Applicants**. Income must be calculated as a monthly amount for all other applicants. To be eligible the applicant parents, caretaker relatives, pregnant women and ineligible non-citizens countable income must be equal to or less than the monthly income limit for the appropriate Medicaid program. (4-1-03)T

03. **Income For Retroactive Medicaid**. Eligibility for retroactive Medicaid is determined by using actual income amounts for each of the three (3) retroactive months. Eligibility for each retroactive month is determined separately. (4-1-03)T

348. ~~***DETERMINING INCOME AVAILABLE TO THE HOUSEHOLD***~~ **ACTUAL AND ANTICIPATED INCOME.**
~~*Income from financially responsible household members is counted for Medicaid eligibility. Income is available when the participant has a legal interest in a liquidated sum. Income must be under the control of the participant during the period for which need is being determined. Income is available when action can be taken by the individual to obtain or use it. The participant must take all necessary steps to obtain program benefits for which he may be eligible. This includes RSDI, unemployment insurance, and worker's compensation.*~~ The Department will establish a reasonable estimate of expected monthly or annual income based on income information from the applicant and other third party sources. To determine the monthly or annual income, actual income already received and income that can reasonably be expected or anticipated will be used. ~~*(3-30-01)*~~(4-1-03)T

01. **Expected Income**. When no changes are expected, the actual income received in the past thirty (30) days will be used. The anticipated income must be used if changes are expected. (4-1-03)T

02. **Seasonal Income**. If income changes seasonally, the applicant's income for the last twelve (12) months including any pay changes will be used to anticipate monthly or annual income. (4-1-03)T

03. **Fluctuating Income**. When applicant's hours of work fluctuate each pay period and the rate of pay remains the same, the income from the past thirty (30) days will be used to determine the monthly or annual income. (4-1-03)T

04. **Salaried Income**. Salaried income is counted at the monthly rate, not at an hourly rate. (4-1-03)T

349. ~~***CALCULATING A FULL MONTH'S INCOME USING ACTUAL AND PROJECTED INCOME***~~ **CONVERTING INCOME TO AN ANNUAL AMOUNT.**
~~*Calculate the monthly income, using actual income already received during the month and income expected to be received in the month. The household and the Department must agree this is a reasonable estimate of that month's income.*~~ To convert the income to an annual amount, use the appropriate formula in Subsections 349.01 through 349.03 of these rules. The annual amount is the total amount of income for twelve (12) months, beginning the month of application. ~~*(3-30-01)*~~(4-1-03)T

01. ~~***Full Month's Income Expected From An Ongoing Source***~~~~*. If no changes are expected, use the actual income received in the past thirty (30) days to project a full month's income. If changes are expected, project the income for the month with the new information.*~~ **Weekly Income**. Multiply weekly income times four point three (4.3) times the number of months the income will be received during the twelve (12) months, beginning with the month of application. ~~*(3-30-01)*~~(4-1-03)T

02. ~~***Full Month's Income Not Expected From An Ongoing Source***~~~~*. If a full month's income is not expected from an ongoing source, count the income expected for the month. If the actual amount is known, use the actual income. If the actual income is unknown, project the expected income for that month.*~~ **Bi-Weekly Income**. Multiply bi-weekly income times two point fifteen (2.15) times the number of months the income will be received during the twelve (12) months, beginning with the month of application. ~~*(3-30-01)*~~(4-1-03)T

03. ~~***Full Month's Income Not Expected From A New Source***. *If income is from a new source, and a full month's income is not expected, count the actual income expected for the month. Do not convert the new source of income to a monthly amount. If the actual income is unknown, project the expected income for that month.*~~ **Semi-Monthly Income**. Multiply semi-monthly income times two (2) times the number of months the income will be received during the twelve (12) months, beginning with the month of application. ~~*(3-30-01)*~~(4-1-03)T

~~***04.*** ***Income From Terminated Source***. *If income is from a terminated source, and no additional income is expected in a future month, count the actual income received during the month. Do not convert income to a monthly amount, if a full month's income from the terminated source is not expected.* *(3-30-01)*~~

~~***05.*** ***Seasonal Income***. *If income changes seasonally, consider the household's income from the last season and any pay changes to project the month's income.* *(3-30-01)*~~

~~***06.*** ***Fluctuating Income***. *When income fluctuates each pay period, and the rate of pay remains the same, average the income from the past thirty (30) days to determine the average pay period amount. Convert the average pay period amount to a full month's income.* *(3-30-01)*~~

~~***07.*** ***Income Paid As Salary***. *Count income paid as salary at the expected monthly salary rate. Do not count salary at an hourly rate.* *(3-30-01)*~~

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.03 - RULES GOVERNING CHILD SUPPORT SERVICES

DOCKET NO. 16-0303-0301

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 7-1206, 32-1209, 32-1217, 32-1214G, 56-203A, and 56-1004, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the September 3, 2003 Administrative Bulletin, Volume 03-9, pages 101 and 102.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Terri Meyer at (208) 334-6673.

DATED this 8th day of October, 2003.

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IDAPA 16, TITLE 03, CHAPTER 03

RULES GOVERNING CHILD SUPPORT SERVICES

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-9, September 3, 2003, pages 101 and 102.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.03 - RULES GOVERNING CHILD SUPPORT SERVICES

DOCKET NO. 16-0303-0301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 7-1206, 32-1209, 32-1217, 32-1214G, 56-203A, and 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 17, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

This rule is being published to comply with provisions of Section 32-1214, Idaho Code, requiring the enforcement of the health coverage provision in a child support order. It sets forth administrative procedures in order for the Department to provide information on how to secure medical support information, the obligor parent's ability to request and administrative review and enforcement of the health care coverage provision in a child support order.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(b), Idaho Code and are necessary in order to comply with deadlines in amendments to governing law and federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule is mandated to comply with Idaho law and federal requirements.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Terri Meyer at (208) 334-6673.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before September 24, 2003.

DATED this 23rd day of July, 2003.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0303-0301

308. -- ~~5~~499. (RESERVED).

~~6~~500. SECURING MEDICAL SUPPORT INFORMATION~~*—AND SECURING AND ENFORCING MEDICAL SUPPORT*~~.

~~***01. Obtaining Information.***~~ Child Support Services ~~*shall*~~ must obtain information as to whether ~~*the non-custodial*~~ either parent has a health insurance policy ~~*and, if so, the policy name(s) and number(s) and name(s) of person(s) covered in any case for which an assignment of support rights is*~~ in effect. Child Support Services must obtain the names of both parents' employers. ~~*The i*~~Information about available medical insurance will be provided to the ~~*applicant/recipient*~~ other parent. ~~*(7-1-98)*~~(7-1-03)T

~~02~~501. SECURING AND ENFORCING MEDICAL SUPPORT~~*-OBLIGATIONS*~~.
Medical support enforcement services ~~*shall*~~ must be provided in any case for which an assignment of medical support is in effect, including: ~~*(7-1-98)*~~(7-1-03)T

~~***a***~~**01. Petition**. Petitioning the court to include health insurance that is available to ~~*the non-custodial*~~ either parent at reasonable cost in new or modified court orders for support. Health insurance is considered reasonable in cost if it is available through employment ~~*related*~~ or other group health ~~*insurance, regardless of service delivery mechanism;*~~ benefit plan. ~~*(7-1-98)*~~(7-1-03)T

~~***b***~~**02. Enforcement**. Taking any necessary action to ensure that ~~*the non-custodial*~~ one (1) parent secures and maintains medical insurance required by the support order. ~~*(7-1-98)*~~(7-1-03)T

502. ADMINISTRATIVE REVIEW FOR ENFORCEMENT OF MEDICAL SUPPORT.

01. Request. An obligor may request an administrative review within twenty (20) days after a notice of intent to enroll one (1) or more children in a health benefit plan is mailed by the Department. (7-1-03)T

02. Scope Of Administrative Review. The Department will cancel a notice of intent to enroll or a National Medical Support Notice (NMSN) if: (7-1-03)T

a. The parent does not owe medical support. (7-1-03)T

b. The parent is no longer obligated to provide medical support. (7-1-03)T

c. Medical support, excluding Medicaid, is already being provided by either parent. (7-1-03)T

503. -- 600. (RESERVED).

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-0202

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: Effective date of the amended temporary rule is October 1, 2002. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section(s) 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 39-106(1)(a), 56-202, 56-203, 56-1004, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The URL in Subsections 533.01 and 550.31 are incorrect, the correct address is http://www.fns.usda.gov/fsp/rules/Memo/02/FY02_Allot_Deduct.htm. The original text of the proposed rules was published in the November 6, 2002, Administrative Bulletin, Volume 02-11, pages 36 through 46.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Phil Gordon, (208) 334-5818.

DATED this 10th day of December, 2002.

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IDAPA 16, TITLE 03, Chapter 04

RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 02-11, November 6, 2002, pages 36 through 46.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0304-0202

SUBSECTION 533.01

533. INCOME DEDUCTIONS.
A household is entitled to a deduction when it gets a bill or, if there is no bill, when the payment is due. Only the deductions listed below must be taken from household's gross income: (6-1-94)

01. Standard Deductions. The standard deductions are controlled by Federal law. The monthly amounts are specified in Title 7 United States Code Section 2014. Current deductions may be found at: http://www.fns.usda.gov/fsp/~~*MENU/ADMIN/CERTIFICATION*~~rules/Memo/02/FY0~~*3*~~2_Allot~~&~~_Deduct.htm.
~~*(10-1-02)T*~~(10-1-02)T

SUBSECTION 550.31

550. STEPS TO COMPUTE FOOD STAMP PAYMENT.
Use the steps in Subsections 550.01 through 550.38 of this rule to compute the Food Stamp issuance. Do not round figures or calculations of income and deductions in determining gross or net income. (10-1-02)T

31. Step 31. Subtract half adjusted income (Step 22) from amount in Step 30. THIS IS THE EXCESS SHELTER DEDUCTION. If any member of the household is age sixty (60) or disabled, use the full excess shelter allowance. For all other households use the excess shelter deduction up to the maximum specified in Title 7 United States Code Section 2014. Current deductions may be found at: http://www.fns.usda.gov/fsp/~~*MENU/ADMIN/CERTIFICATION*~~rules/Memo/02/FY0~~*3*~~2_Allot~~&~~_Deduct.htm. ~~*(10-1-02)T*~~(10-1-02)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-0202

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective October 1, 2002.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 39-106(1)(a), 56-202, 56-203, and 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than November 20, 2002.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

These changes are to bring current rules into compliance with recent changes in Federal statutes and to reflect changes in the Code of Federal Regulations.

This rule is being amended to: remove the requirement that legal and qualified immigrants who receive disability benefits be legally present in the U. S. as of August 22, 1996 in order to be eligible to receive Food Stamps, add references throughout the rule to the disability criteria in IDAPA 16.03.04 Subsections 216.02 through 216.10, add a new non-TAFI participant student exemption from JSAP and delete references to SSI being a means-tested program. The changes also update: the total number of weekly hours for part-time employment, references to standard income deductions, and the gross monthly income eligibility standards, net monthly income eligibility standards and maximum food stamp benefit.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(b), Idaho Code, and are necessary in order to comply with deadlines in amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes in the rule were made to bring rules into compliance with recent changes in Federal statutes and regulations.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Phil Gordon, (208) 334-5818.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before November 27, 2002.

DATED this 24th day of September, 2002.

Sherri Kovach
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0304-0202

204. CITIZENSHIP OR SATISFACTORY IMMIGRATION STATUS.
A person must be a U. S. resident to get Food Stamps. A person must be a U.S. citizen, a U.S. non-citizen national, or a qualified legal non-citizen to get Food Stamps. To be eligible for Food Stamps, legal non-citizens must meet a category in Subsections 204.01 through 204.1~~0~~1 of this rule. ~~(3-15-02)~~(10-1-02)T

01. Permanent Residents. A non-citizen lawfully admitted to the United States for permanent residence is eligible indefinitely if meeting a condition in Subsection 204.01.a. or 204.01.b. of these rules: ~~(3-15-02)~~(10-1-02)T

a. The non-citizen is a veteran honorably discharged for a reason other than alienage, or is on active duty in the U.S. Armed Forces for other than training, or is the spouse or unmarried dependent of ~~the~~ a veteran or person on active duty. ~~(3-15-02)~~(10-1-02)T

b. The non-citizen has forty (40) quarters of work. A quarter worked by the legal non-citizen's parent, while the legal non-citizen was under age eighteen (18) and a quarter worked by the legal non-citizen's spouse during marriage if the legal non-citizen remains married to the spouse or the spouse is deceased can be counted as a quarter of work for the legal non-citizen. Any quarter after January 1, 1997, in which a legal non-citizen received any Federal means-tested benefit is not counted as a quarter of work. (3-15-02)

02. Lawful Non-Citizen, Permanent Residents Residing In The U.S. On August 22, 1996. Lawful non-citizen, permanent residents residing in the U. S. on August 22, 1996 who are: (4-5-00)

~~*a. Blind or disabled of any age under the disability criteria listed in Subsections 216.02 through 216.10; or* (4-5-00)~~

~~*b*~~**a.** Sixty-five (65) years of age or older, at that time; or (4-5-00)

~~*c*~~**b.** A child who is now under the age of eighteen (18). (4-5-00)

03. Lawful Non-Citizen, Permanent Residents Who Are Blind Or Disabled. Lawful non-citizen, permanent residents who are blind or disabled and meet one (1) of the disability criteria listed in Subsections 216.02 through 216.10 of these rules. (10-1-02)T

0~~3~~4. Refugees. A refugee admitted under Section 207 of the Immigration and Nationality Act, a Cuban/Haitian entrant as defined in Section 501(e) of the Refugee Assistance Act of 1980, or an Amerasian admitted under Section 584 of Public Law 100-202 and amended by Public Law 100-461, is eligible: ~~(7-1-99)~~(10-1-02)T

a. For seven (7) years from refugee's date of entry; or (4-5-00)

b. With no time limit if the refugee is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty. ~~(7-1-99)~~(10-1-02)T

0~~4~~5. **Asylees**. An asylee admitted under Section 208 of the Immigration and Nationality Act is eligible: (7-1-99)

a. For seven (7) years from the date asylee status is assigned; or (4-5-00)

b. With no time limit if the asylee is a veteran honorably discharged for a reason other than alienage, or on active duty for other than training in the U.S. Armed Forces, or the spouse or unmarried dependent of the veteran or person on active duty. ~~(7-1-99)~~(10-1-02)T

0~~5~~6. **Deportation Withheld**. An individual whose deportation has been withheld under Section 241(b)(3) or 243(h) of the Immigration and Nationality Act is eligible: (7-1-99)

a. For seven (7) years from the date deportation was withheld; or (4-5-00)

b. With no time limit if the deportee is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty. ~~(7-1-99)~~(10-1-02)T

0~~6~~7. **Conditional Entrants**. A conditional entrant admitted under Section 203(a)(7) of the Immigration and Nationality Act who is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty. ~~(7-1-99)~~(10-1-02)T

0~~7~~8. **Parolees**. A person paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one (1) year who is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty. ~~(7-1-99)~~(10-1-02)T

0~~8~~9. **Battered Non-Citizen**. A legal non-citizen admitted to the United States as a battered non-citizen under Section 204(a)(1)(A), or 204(a)(1)(B) of the Immigration and Nationality Act (INA), as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA who is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty. ~~(7-1-99)~~(10-1-02)T

~~09~~10. **Certain Hmong and Highland Laotians**. Certain Hmong and Highland Laotians who were: (4-5-00)

a. Members of a Hmong or Highland Laotian tribe at the time the tribe rendered assistance to United States personnel by taking part in a military or rescue operation during the Vietnam era beginning August 5, 1964 and ending May 7, 1975; or (4-5-00)

b. The spouse or unmarried dependent child of such an individual; or (4-5-00)

c. The unremarried surviving spouse of such an individual who is deceased. (4-5-00)

1~~0~~1. **Native Americans**. Native Americans with treaty rights to cross the U.S. borders, American Indians born in Canada to whom the provisions of Section 289 of the Immigration and Nationality Act apply, or members of an Indian tribe as defined in Section 4(e) of the Indian Self-Determination and Education Assistance Act. (4-5-00)

(BREAK IN CONTINUITY OF SECTIONS)

267. GOOD CAUSE FOR VOLUNTARILY QUITTING A JOB OR REDUCING WORK HOURS. If a household member voluntarily quits a job, determine if the quit was for good cause. All facts and circumstances submitted by the household and the employer must be considered. Good cause includes~~, *but is not limited to,*~~ the reasons listed below: ~~*(4-5-00)*~~(10-1-02)T

01. Personal Difficulties. Personal difficulties include: (10-1-02)T

a. Health problems; (10-1-02)T

b. Structured drug and alcohol treatment; (10-1-02)T

c. Jailed or necessary court appearances; and (10-1-02)T

d. Conflicts with verified and practiced religious and ethical beliefs. ~~*(6-1-94)*~~(10-1-02)T

02. Family Emergencies. Family emergencies include: (10-1-02)T

a. Crisis in family health; and (10-1-02)T

b. Child legal or behavioral problems. ~~*(7-1-98)*~~(10-1-02)T

03. Environmental Barriers. Environmental barriers include: (10-1-02)T

a. Weather conditions preventing the person from reaching the work site; (10-1-02)T

b. Unexpected loss of transportation; and (10-1-02)T

c. Housing or utility problems requiring immediate attention. ~~*(6-1-94)*~~(10-1-02)T

04. Work Site Problems. Work site problems include: (10-1-02)T

a. Temporary layoff from a regular, full-time job. The person must be able to return to the job within ninety (90) days~~.~~; (10-1-02)T

b. Work site conditions not meeting legal or local standards of health and safety, hours, pay, or benefits~~.~~; and (10-1-02)T

c. Alleged discrimination on the job site. ~~*(6-1-94)*~~(10-1-02)T

05. Employment Or School. The household member accepts employment, or enrolls at least half-time in any recognized school, training program, or an institution of higher education. (4-5-00)

06. Employment Or School In Another Area. Another household member accepts employment in another area, requiring the household to move. Another household member enrolls at least half-time in a recognized school, a training program, or an institution of higher education in another area, requiring the household to move. (6-1-94)

07. Retirement. Persons under age sixty (60) resign, if the resignation is recognized as retirement. (6-1-94)

08. Full Time Job Does Not Develop. A person accepts a bona fide offer of a full time job. The job does not develop. The job results in employment of less than ~~*twenty*~~ thirty (~~*2*~~30) hours a week, or weekly earnings of less than the Federal minimum wage multiplied by ~~*twenty*~~ thirty (~~*2*~~30) hours. ~~*(6-1-94)*~~(10-1-02)T

09. Temporary Pattern Of Employment. Person leaves a job where workers move from one (1) employer to another, such as migrant farm labor or construction work. Households may apply for benefits between jobs, when work is not yet available at the new site. Even though the new employment has not actually begun, the

previous quit is with good cause if it is the pattern of that type of employment. (6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

276. FAILURE TO COMPLY WITH A REQUIREMENT OF ANOTHER MEANS - TESTED PROGRAM.
Food Stamps must not increase when a failure to comply causes other means-tested benefits to decrease. Benefits from means-tested programs like TAFI ~~*and SSI*~~ may decrease due to failure to comply with a program requirement. Food Stamp benefits must not increase because of this income loss. If a reduction in benefits from another means-tested program occurs, verify the reason for the reduction. If the reason for the reduction cannot be verified, document the case record to reflect the good faith effort to verify the information. ~~*(7-1-98)*~~(10-1-02)T

277. PENALTY FOR FAILURE TO COMPLY WITH A REQUIREMENT OF ANOTHER MEANS - TESTED PROGRAM.
~~*The*~~ To prevent an increase in Food Stamp benefits, penalties will be applied to ~~*the*~~ a Food Stamp case for failure to comply with a requirement of another means-tested program ~~*to prevent an increase in Food Stamp benefits are listed in Subsections 277.01 and 277.02*~~ such as TAFI. When a Food Stamp recipient fails to comply with a requirement of the TAFI program, count that portion of the benefit decrease attributed to the TAFI penalty. Conditions for ending the penalty are listed in Subsections 277.01 through 277.03 of this rule. ~~*(7-1-98)*~~(10-1-02)T

~~***01. Failure To Comply With A TAFI Requirement**. When a Food Stamp recipient fails to comply with a requirement of the TAFI program count that portion of the benefit decrease attributed to the TAFI penalty. Conditions for ending the penalty are listed below. (7-1-98)***~~

~~***a***~~**01. Time-Limited TAFI Penalty**. If the TAFI penalty is time-limited, end the FS penalty when the TAFI penalty is ended. (7-1-98)

~~***b***~~**02. Lifetime TAFI Penalty**. If the TAFI penalty is a lifetime penalty, apply the FS penalty for a length of time to match the remaining months of TAFI eligibility for the household. End the FS penalty if the household subsequently reapplies for TAFI and is denied for a reason other than the noncompliance that caused the TAFI penalty. (7-1-98)

~~***c***~~**03. Member Who Caused The TAFI Penalty Leaves The Household**. End the FS penalty when the member who caused the TAFI penalty leaves the household. (7-1-98)

~~***02. Failure To Comply With A Requirement Of A Means-Tested Program Such As SSI**. For a failure to comply with a requirement of another means-tested program, such as SSI, which results in a reduction of benefits, count that portion of the benefit decrease which is attributed to the penalty. (7-1-98)***~~

(BREAK IN CONTINUITY OF SECTIONS)

305. RESOURCE LIMIT.
The Food Stamp resource limit for households with one (1) member who is age sixty (60) or over, or disabled, is three thousand dollars ($3,000). The resource limit is three thousand dollars ($3,000), even if the person age sixty (60) or over is the only person in the household. The resource limit for other households is two thousand dollars ($2,000). To be considered as disabled, a person must meet one (1) of the criteria listed in Subsections 216.02 through 216.10 of these rules. ~~*(6-1-94)*~~(10-1-02)T

306. CHANGE IN RESOURCE LIMIT.
The Food Stamp resource limit changes from two thousand dollars ($2,000) to three thousand dollars ($3,000) the month a household member turns age sixty (60) or when the household member is disabled and meets one (1) of the criteria listed in Subsections 216.02 through 216.10 of these rules. ~~*(6-1-94)*~~(10-1-02)T

307. RESOURCES AND CHANGE IN HOUSEHOLD MEMBERS.
A change in household members can change the resource limit. If a household gains one member age sixty (60) or older, or who is disabled, the resource limit changes the month the Department adds the member to the Food Stamp household. If a household loses all members age sixty (60) or older, or who is disabled, the resource limit changes the month the Department removes the member from the Food Stamp household. ~~*(6-1-94)*~~(10-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

512. SPECIAL CASES FOR COUNTING INCOME.
Special cases for counting income are listed below: (6-1-94)

01. Wages Held At The Request Of Employee. Wages held at the request of the employee are income in the month the wages would have been paid by the employer. (6-1-94)

02. Garnishments Held By Employer. Garnishments withheld by an employer are income in the month the wages would have been paid. (6-1-94)

03. Wages Held By Employer, Other Than Garnishment And Employee Request. Wages held by the employer, even if in violation of law, are not counted as income. (6-1-94)

04. Advances On Wages. Advances on wages will count as income if the household reasonably expects the advance to be paid. (6-1-94)

05. Varying Payment Cycles. Households getting unearned or earned income on a recurring monthly or semi-monthly basis do not have varying income merely because mailing or payment cycles cause additional payments to be received in a month. The income is counted for the month it is intended. (7-1-98)

06. Nonrecurring Lump Sum Payments And Capital Gains. Nonrecurring lump sum payments must not be counted as income. Nonrecurring lump sum payments are counted as a resource starting in the month received. Nonrecurring lump sum payments include capital gains from the sale or transfer of securities, real estate, or other real property held as an investment for a set period of time. The capital gains are income only if the assets were used in self-employment. (6-1-94)

07. ~~*SSI Or*~~ PA Entitlement. If a household intentionally fails to comply with a means-tested program, a penalty may be imposed and benefits reduced to collect the means-tested program overpayment. Means-tested programs include ~~*SSI or*~~ PA. Count the full amount of means tested benefits the household is entitled to, not the reduced amount caused by the failure to comply. ~~*(7-1-98)*~~(10-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

532. GROSS INCOME LIMIT.
Households exceeding the gross income limit for the household size are not eligible, unless they are categorically eligible or have an elderly or disabled member. Categorically eligible households are exempt from gross and net income limits. All members of categorically eligible households must be approved for TAFI, AABD, or SSI. Households with elderly or disabled household members are exempt from the gross income limit. Gross income limits are listed in Table 532.

TABLE 532 - GROSS INCOME LIMIT	
Household Size	**Gross Income Limit**
1	$~~*931*~~ 960
2	$~~*1,258*~~ 1,294
3	$~~*1,585*~~ 1,628
4	$~~*1,913*~~ 1,961
5	$~~*2,240*~~ 2,295
6	$~~*2,567*~~ 2,629
7	$~~*2,894*~~ 2,962
8	$~~*3,221*~~ 3,296
Each Added Person	Add $~~*328*~~ 334

~~*(10-1-01)T*~~(10-1-02)T

533. INCOME DEDUCTIONS.
A household is entitled to a deduction when it gets a bill or, if there is no bill, when the payment is due. Only the deductions listed below must be taken from household's gross income: (6-1-94)

01. Standard Deductions. The standard deductions ~~*is*~~ are controlled by Federal law. ~~*t*~~The monthly amounts are specified in Title 7 United States Code Section 2014. Current deductions may be found at: http://www.fns.usda.gov/fsp/MENU/ADMIN/CERTIFICATION/FY03Allot&Deduct.htm. ~~*(4-5-00)*~~(10-1-02)T

02. Earned Income Deduction. The earned income deduction is twenty percent (20%) of gross earned income. (6-1-94)

03. Excess Medical Deduction. The excess medical deduction is nonreimbursed medical expenses more than thirty-five dollars ($35) per household per month. The household member must be either age sixty (60) or older or disabled to get this deduction. Special diets are not deductible. (6-1-94)

04. Dependent Care Deduction. The dependent care deduction each month is dependent care expenses up to a maximum of two hundred dollars ($200) per dependent child under age two (2) and one hundred seventy-five dollars ($175) for any other dependent. The care must be needed for a household member to accept, continue, or seek employment, or attend school or training for employment. (9-1-94)

05. Child Support Deduction. The child support deduction is the legally obligated child support amount the household pays, or expects to pay, on behalf of a non-household member. (7-1-97)

06. Shelter Costs. The monthly shelter cost~~,~~ over fifty percent (50%) of the household's income after all other deductions~~,~~ is the excess shelter cost. ~~*(6-1-94)*~~(10-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

543. STANDARD UTILITY ALLOWANCE (SUA).
The shelter deduction is computed using the SUA or actual utility costs. The Standard Utility Allowance (SUA) can be used instead of actual costs of heating, cooling, cooking fuel, electricity, the basic service fee for one (1)

telephone, water, sewer and garbage collection. The SUA is two hundred ~~*thirty-one*~~ forty-four dollars ($2~~*31*~~44). The household must be told if actual utility costs exceed the SUA, the actual costs can be used if the household proves these costs. To qualify for the SUA, households must receive direct or indirect energy assistance payments made under the Low Income Home Energy Assistance Act of 1981 (LIHEAP); or meet the conditions in Subsections 543.01 through 543.06 of this rule. ~~*(3-15-02)*~~(10-1-02)T

01. Primary Heating Or Cooling System. The household must have a primary heating or cooling system to qualify for the SUA. A primary heating system is a central heating system, or space heating stove, used to heat the living quarters of the home. A cooling system is a central air conditioning system or a room air conditioner. The household must have out-of-pocket heating or cooling costs billed on a regular or irregular basis. The heating or cooling costs must be separate from rent or mortgage payments. This includes households in private rental housing, billed by their landlords for individual usage or charged a flat rate, separately from rent. If not billed regularly for heating or cooling costs, the household must be otherwise Food Stamp eligible between billing periods. (3-15-02)

02. Cooling Costs. If the household claims cooling costs, the household must have either an air conditioning system or a room air conditioner to qualify for the SUA. (3-15-02)

03. Heating Costs. If the household claims heating costs, the household must have expenses for a primary source of heat. Households buying wood for their primary source of heat may get the SUA. Cutting their own wood for the primary source of heat does not qualify a household for the SUA. Supplemental heat sources like, space heaters, electric blankets, cook stoves and a secondary heat source like a fireplace do not qualify households for the SUA. (3-15-02)

04. Energy Assistance Excluded From Income. If the household gets direct or indirect energy assistance that is excluded from income, the household gets the SUA if the amount of the expense exceeds the amount of the assistance. (3-15-02)

05. Energy Assistance Not Excluded From Income. If a household gets energy assistance that is not excluded from income, the household must also have out-of-pocket heating or cooling costs to get the SUA. (3-15-02)

06. Occupied And Unoccupied Home. A household with both an occupied home and an unoccupied home, is limited to one (1) SUA. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

549. NET INCOME LIMIT TEST.
Categorically eligible households do not have a net income limit. For all other households, including those with an elderly or disabled household member, compare the net income to the net income eligibility limit for that size household. This comparison must be completed for initial eligibility and when income changes. When the household income changes to a different income eligibility limit, apply the different limit. If the net income of the household exceeds the net income limit the household is not eligible for Food Stamps, unless categorically eligible. Net income limits are listed in Table 549.

TABLE 549 - NET INCOME LIMITS	
Household Size	**Net Income Limit**
1	$~~*716*~~ 739
2	$~~*968*~~ 995
3	$~~*1,220*~~ 1,252
4	$~~*1,471*~~ 1,509

TABLE 549 - NET INCOME LIMITS	
Household Size	**Net Income Limit**
5	$~~*1,723*~~ 1,765
6	$~~*1,975*~~ 2,022
7	$~~*2,226*~~ 2,279
8	$~~*2,478*~~ 2,535
Each Added Person Add	$~~*252*~~ 257

~~*(10-1-01)T*~~(10-1-02)T

550. STEPS TO COMPUTE FOOD STAMP PAYMENT.
Use the steps in Subsections 550.01 through 550.38 of this rule to compute the Food Stamp issuance. Do not round figures or calculations of income and deductions in determining gross or net income. ~~*(7-1-97)*~~(10-1-02)T

01. **Step 1**. List projected wages and salaries for the household for the month. Do not count excluded income. (6-1-94)

02. **Step 2**. Compute and list net self-employment income. If a farmer, list any self-employment profit or loss. (6-1-94)

03. **Step 3**. Add results of Step 1 and Step 2. THIS IS GROSS EARNED INCOME. (6-1-94)

04. **Step 4**. Compute and list prorated monthly non-excluded educational income. (6-1-94)

05. **Step 5**. Compute and list prorated monthly tuition, mandatory fees, and allowed expenses. (6-1-94)

06. **Step 6**. Subtract amount in Step 5 from the amount in Step 4. (6-1-94)

07. **Step 7**. List other unearned income for household. (6-1-94)

08. **Step 8**. Add results of Step 6 and Step 7. THIS IS TOTAL UNEARNED INCOME. (6-1-94)

09. **Step 9**. Add results of Step 3 and Step 8. (6-1-94)

10. **Step 10**. Subtract any loss not used up in Step 2 from Step 9. THIS IS GROSS MONTHLY INCOME. Record the gross monthly income. Check to see if gross income exceeds the limit for family size. Categorically eligible households are exempt from the gross income test. Households with an elderly or disabled household member are exempt from the gross income test. (6-1-94)

11. **Step 11**. Multiply amount in Step 3 times twenty percent (20%). (6-1-94)

12. **Step 12**. Subtract amount in Step 11 from amount in Step 3. (6-1-94)

13. **Step 13**. Add amount in Step 12 to amount in Step 8. (6-1-94)

14. **Step 14**. List the standard deduction. (4-5-00)

15. **Step 15**. Subtract amount in Step 14 from amount in Step 13. (6-1-94)

16. **Step 16**. List converted medical costs over thirty-five dollars ($35) for household with elderly or disabled member. (6-1-94)

17. **Step 17**. Subtract amount in Step 16 from amount in Step 15. (6-1-94)

18. **Step 18**. List converted dependent care costs (not to exceed two hundred dollars ($200) per dependent under age two (2) and one hundred seventy five dollars ($175) for any other dependent). (10-1-94)

19. **Step 19**. Subtract amount in Step 18 from amount in Step 17. (7-1-97)

20. **Step 20**. List child support paid or expected to be paid by the household. (7-1-97)

21. **Step 21**. Subtract amount in Step 20 from amount in Step 19. THIS IS INCOME, AFTER DEDUCTIONS, EXCEPT SHELTER DEDUCTION. (7-1-97)

22. **Step 22**. Divide amount in Step 21 by two (2) (this is used to weigh shelter costs). THIS IS HALF THE ADJUSTED INCOME. (7-1-97)

23. **Step 23**. List rent or mortgage payment. (7-1-97)

24. **Step 24**. List property taxes (averaged over twelve (12) months). (7-1-97)

25. **Step 25**. List homeowners insurance on structure (averaged over twelve (12) months). (7-1-97)

26. **Step 26**. Add amount in Step 23 and amount in Step 24 and amount in Step 25. (7-1-97)

27. **Step 27**. If client chooses the standard utility allowance (SUA), add the SUA to the amount in Step 26. (4-5-00)

28. **Step 28**. If client has chosen to use actual utility expenses, list and add the following expenses~~.~~: ~~(7-1-97)~~(10-1-02)T

a. Basic rate for telephone. (6-1-94)

b. Electric bill. (6-1-94)

c. Gas bill. (6-1-94)

d. Heating oil. (6-1-94)

e. Wood costs (only if purchased for heat). (6-1-94)

f. Water and sewer bill. (6-1-94)

g. Garbage and trash collection. (6-1-94)

h. Installation costs for utilities. (6-1-94)

i. Other allowed utility costs. (6-1-94)

29. **Step 29**. If client has chosen to use actual utility expenses, add amount in Step 26 and amount in Step 28. (7-1-97)

30. **Step 30**. Use amount from Step 27 (using standard utility allowance) or amount from Step 29 (using actual utility costs) as total shelter cost. (7-1-97)

31. **Step 31**. Subtract half adjusted income (Step 22) from amount in Step 30. THIS IS THE EXCESS SHELTER DEDUCTION. If any member of the household is age sixty (60) or disabled, use the full excess shelter allowance. For all other households use the excess shelter deduction up to the maximum specified in Title 7 United States Code Section 2014. Current deductions may be found at: http://www.fns.usda.gov/fsp/MENU/ADMIN/

CERTIFICATION/FY03Allot&Deduct.htm. ~~*(4-5-00)*~~(10-1-02)T

32. **Step 32**. Subtract amount in Step 31 from amount in Step 21. THIS IS THE NET INCOME. (7-1-97)

33. **Step 33**. List maximum net income limit based on household size. (7-1-97)

34. **Step 34**. If amount in Step 32 is less than or equal to amount in Step 33, or if all household members are categorically eligible, compute the Food Stamp amount. If the amount in Step 32 is greater than the amount in Step 33, net income exceeds allowed limits. (7-1-97)

35. **Step 35**. List maximum Food Stamp amount for number of eligible household members. (7-1-97)

36. **Step 36**. Multiply amount in Step 32 times three-tenths (0.3) (thirty percent (30%)). (7-1-97)

37. **Step 37**. Subtract amount in Step 36 from the amount in Step 35. (7-1-97)

38. **Step 38**. Round the amount in Step 37 to the next lower dollar. THIS IS THE FOOD STAMP ISSUANCE AMOUNT. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

581. MAXIMUM FOOD STAMPS BY HOUSEHOLD SIZE.
The maximum Food Stamp amount by household size is listed in Table 581.

TABLE 581 - MAXIMUM FOOD STAMPS BY HOUSEHOLD SIZE	
Household Size	**Maximum Food Stamps**
1	$~~*135*~~ 139
2	$~~*248*~~ 256
3	$~~*356*~~ 366
4	$~~*452*~~ 465
5	$~~*537*~~ 553
6	$~~*644*~~ 663
7	$~~*712*~~ 733
8	$~~*814*~~ 838
Each Added Person	Add $~~*102*~~ 105

~~*(10-1-01)T*~~(10-1-02)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-0301

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective dates of the amendments to the temporary rule are April 1, 2003 and July 1, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 39-106(1)(a), 56-202, 56-203, and 56-1004, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Section 204 regarding citizenship and qualified non-citizen requirements was amended to reflect the recommendations received from the federal Food and Nutrition Service (FNS). Most of the existing text was deleted and citations to the governing sections from the Code of Federal Regulations and from the Farm Bill (Public Law 107-171, "Farm Security and Rural Investment Act of 2002") were added.

Pursuant to Section 67-5228, Idaho Code, typographical, transcriptional, and/or clerical corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the October 1, 2003, Administrative Bulletin, Volume 03-10, pages 230 through 242.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Phil Gordon at (208) 334-5818.

DATED this 14th day of November, 2003.

Sherri Kovach, Program Supervisor
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IDAPA 16, TITLE 03, CHAPTER 04

RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-10, October 1, 2003, pages 230 through 242.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0304-0301

SECTION 204 (Entire Section)

204. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible for Food Stamps, an individual must ~~*be a member of one (1) of the groups listed in Subsections 204.01 through 204.14 of this rule*~~ meet the requirements specified in 7 CFR 273.4, "Citizenship and alien status" and in accordance with Public Law 107-171 "Farm Security and Rural Investment Act of 2002," Title IV - Nutrition Programs, Subtitle D - Miscellaneous, Section 4401, regarding the partial restoration of benefits to legal immigrants. ~~*(4-1-03)T*~~(4-1-03)T

~~***01. U.S. Citizen**. A U.S. Citizen; or* *(4-1-03)T*~~

~~***02. U.S. National**. A U.S. National; or* *(4-1-03)T*~~

~~***03. Full-Time Active Duty U.S. Armed Forces Member**. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who is currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member; or* *(4-1-03)T*~~

~~***04. Veteran Of The U.S. Armed Forces**. A qualified non-citizen as defined in 8 U.S.C. 1641 (b) or (c) who was honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran; or* *(4-1-03)T*~~

~~***05. Refugees And Others Fleeing Persecution**. A non-citizen who was:* *(4-1-03)T*~~

~~***a.** Admitted into the U.S. as a refugee under 8 U.S.C. 1157 (including those who have adjusted to lawful permanent resident status); or* *(4-1-03)T*~~

~~***b.** Granted asylum under 8 U.S.C. 1158 (including those who have adjusted to lawful permanent resident status); or* *(4-1-03)T*~~

~~**c.** *Granted withholding of deportation or removal under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208 (including those who have adjusted to lawful permanent resident status); or* (4-1-03)T~~

~~**d.** *Admitted into the U.S. as an Amerasian immigrant under Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in Section 101(e) of Public Law 100-202 and amended by the 9th proviso under migration and refugee assistance in Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended); or* (4-1-03)T~~

~~**e.** *Granted status as a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Assistance Act of 1980 (including those who have adjusted to lawful permanent resident status); or* (4-1-03)T~~

~~**06. Qualified Non-Citizen For At Least Five Years**. *A qualified non-citizen under 8 U.S.C. 1641(b) or (c), who has had a qualified non-citizen status for at least five (5) years; or* (4-1-03)T~~

~~**07. Lawful Permanent Resident (LPR) with Forty Quarters Of Work History**. *A lawful permanent resident (LPR) who has forty (40) quarters of work history under Title II of the Social Security Act, or can be credited with that work history under 8 U.S.C. 1645; or* (4-1-03)T~~

~~**08. Qualified Non-Citizens Receiving Disability Related Assistance**. *Qualified non-citizens, as defined in 8 U.S.C. 1641(b) or (c), who are receiving benefits or assistance for blindness or disability (within the meaning of Section 3(r) of the Food Stamp Act of 1977 (7 U.S.C. 2012(r))); or* (4-1-03)T~~

~~**09. Qualified Non-Citizen Children**. *Qualified non-citizens, as defined in 8 U.S.C. 1641(b) or (c), who are under age eighteen (18) are eligible for food stamps regardless of their date of entry into the United States; or* (10-1-03)T~~

~~**10. Qualified Non-Citizen Seniors**. *Qualified non-citizens, as defined in 8 U.S.C. Section 1641(b) or (c), who on August 22, 1996 were age sixty-five (65) or over and were lawfully residing in the United States; or* (4-1-03)T~~

~~**11. American Indian Born In Canada**. *An American Indian born in Canada under 8 U.S.C. 1359; or* (4-1-03)T~~

~~**12. American Indian Born Outside The U.S.** *An American Indian born outside of the U.S., and is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e); or* (4-1-03)T~~

~~**13. Certain Hmong And Highland Laotians**. *Hmong and Highland Laotians who were:* (4-1-03)T~~

~~**a.** *Members of a Hmong or Highland Laotian tribe at the time the tribe rendered assistance to United States personnel by taking part in a military or rescue operation during the Vietnam era beginning August 5, 1964 and ending May 7, 1975; or* (4-1-03)T~~

~~**b.** *The spouse or unmarried dependent child of such an individual; or* (4-1-03)T~~

~~**c.** *The unremarried surviving spouse of such an individual who is deceased; or* (4-1-03)T~~

~~**14. Victim Of Severe Form Of Trafficking**. *A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13), who meets one (1) of the following:* (4-1-03)T~~

~~**a.** *Is under the age of eighteen (18) years; or* (4-1-03)T~~

~~**b.** *Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and* (4-1-03)T~~

~~**i.** *Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has*~~

~~*not been denied; or*~~ ~~*(4-1-03)T*~~

~~***ii.*** *Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons.*~~ ~~*(4-1-03)T*~~

SECTION 616 (Entire Section)

616. DECREASES OR CLOSURE OF FOOD STAMPS.

If a change on which the department is required to act results in a decrease or closure of Food Stamps, the Department must provide notice. The change must be effective the first month following timely notice, unless the change does not require ten (10) day advance notice. If the household does not respond to the request for proof, or does respond but refuses to provide sufficient information or fails to provide required proof of a change affecting eligibility by the requested date, send a closure notice. The notice must explain the reason for the closure. The notice must advise the household of the need to submit a new application if it wishes to continue participating in the program. If the household fails to provide required proof of a change affecting Food Stamp amount by the requested date, and the change would result in decreased benefits, no deduction is allowed or benefits are decreased. If the household provides the change verification after the date requested, act on the change as if it was an increase. The effective date of the change is the month after the month the change is verified. ~~*(7-1-03)T*~~(7-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-0301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATES: These temporary rules have effective dates of December 1, 2002; April 1, 2003; July 1, 2003; and October 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 39-106(1)(a), 56-202, 56-203, and 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

The proposed rulemaking makes clarifications to the Social Security Number (SSN) requirements; clarifications and corrections to citizenship and residency requirements; clarification to the rule regarding fugitive felons; clarifications to rule regarding dependent care expenses, earned income, excluded income, and change reporting; clarifications regarding of vendor payment and third-party payments; updates the new Federal 36-month period in the rule regarding work requirements for Able Bodied Adults Without Dependents (ABAWDs); and modifications due to Farm Bill regarding citizenship or satisfactory immigration status and sponsor deeming.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions land deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with deadlines in amendments to governing law or federal programs and to confer a benefit.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because rulemaking occurred to comply with changes mandated in federal regulations and Idaho statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Phil Gordon at (208) 334-5818.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 22, 2003.

DATED this 8th day of August, 2003.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0304-0301

159. ~~*SSN FOR EXPEDITED FOOD STAMPS*~~ (RESERVED).
~~*The household must furnish or apply for a SSN for each person before the second full month of Food Stamps. Household members unable to provide SSNs before the end of the second full month of Food Stamps, and not having good cause for the SSN problem, cannot continue to get Food Stamps. A newborn may participate when the household cannot provide proof of application for an SSN for the newborn. Proof of application for an SSN for that child must be provided at the next recertification or six (6) months after the month the child was born, whichever is later.* *(7-1-98)*~~

(BREAK IN CONTINUITY OF SECTIONS)

203. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.
Before certification, households must provide the Department the SSN, or proof of application for SSN, for each household member. If a household member has more than one (1) SSN, he must provide all of his SSNs. Each SSN must be verified by the Social Security Administration (SSA). A household member with an unverified SSN is not eligible for Food Stamp benefits. The ineligible person's income and resources must be counted in the Food Stamp budget. If benefits are reduced or ended, because one (1) or more persons fail to meet the SSN requirement, the household must be notified in writing. ~~*(7-1-98)*~~(7-1-03)T

~~***01. Religious Objection****. Households declaring a valid religious objection to getting or providing an SSN may get Food Stamps, if otherwise eligible. Document the valid reason for the SSN objection. Tell the household SSNs may be assigned to household members without their cooperation. Tell the household other sources may be used to get SSN data.* *(6-1-94)*~~

02. Appl~~y~~ication For SSN. ~~*If a household member does not have an SSN, he must apply for an SSN. After the member files the SSN application, he may get Food Stamps while the SSN is assigned. If a household member is unable to provide his SSN, he must apply for a duplicate SSN card. If a household member does not know if he has an SSN, he must apply for an SSN. If a household member has a questionable SSN he must apply for an SSN. SSN application process and proof is listed below:* *(7-1-97)*~~(7-1-03)T

a. ~~*Application for SSN or duplicate SSN card. For the household member with a SS card, the Department must tell the household an SS-5 Application for SSN must be filed at an SSA office, give the household an HW 0446 Social Security Number Referral form, and tell the household proof of age, identity, and citizenship must be provided to the SSA.*~~ If a household member does not have an SSN, he must apply for an SSN. After the household member files the SSN application, he may receive Food Stamp benefits while the SSN is assigned. ~~*(3-15-02)*~~(7-1-03)T

b. ~~*Proof of SSN application. The household must prove it applied for an SSN by giving one (1) of three (3) forms to the Department: A completed HW 0446 Social Security Number Referral, signed and dated by SSA, a completed SSA-5028 Evidence of Application for Account Number Card, signed and dated by SSA, a completed SSA-2853 Message From Social Security, signed and dated by a hospital representative. The acquired SSN card is proof of application.*~~ If a household member is unable to provide his SSN, he must apply for a duplicate SSN card. ~~*(6-1-94)*~~(7-1-03)T

c. If a household member does not know if he has an SSN, he must apply for an SSN. (7-1-03)T

d. If a household member has a questionable SSN, he must apply for an SSN. (7-1-03)T

e. If the person is unable to get the proof required by SSA for an SSN, the Department will help the person get proof. (7-1-03)T

0~~3~~2. Proof Of Application For An SSN For A Newborn. A newborn may ~~*participate*~~ receive Food Stamp benefits when the household cannot provide proof of application for an SSN for the newborn. Proof of application for an SSN for that child must be provided at the next Food Stamp recertification or six (6) months after the month the child was born, whichever is later. If the household does not provide proof of SSN or application for SSN, ~~*treat*~~ the child ~~*as a disqualified household member*~~ will be ineligible to receive Food Stamp benefits the month following the month the household failed to provide the proof. ~~*(7-1-98)*~~(7-1-03)T

0~~4~~3. ~~*Expedited Services*~~ SSN Requirements For Expedited Food Stamp Service. ~~*Households getting expedited services must furnish an SSN or apply for an SSN for each person before the second full month of Food Stamp participation. If the application date is the first day of the month and proof is delayed, the household is assigned a normal certification period. For a household applying on the first day of the month, if the SSN or application for SSN is not provided for a household member during the first month, the person is treated as an excluded household member beginning the second month. A newborn may participate when the household cannot provide proof of application for an SSN for the newborn. Proof of application for an SSN for that child must be provided at the next recertification or six (6) months after the month the child was born, whichever is later.*~~ Households entitled to expedited service under the criteria in Section 155 of this chapter of rules will be asked to furnish an SSN or proof of application for SSN for each person in the household applying for benefits before the first day of the second full month of Food Stamp participation. Those household members unable to provide the SSN or who do not have one prior to the second full month of participation may be allowed to continue to participate only if they satisfy the good cause requirements in Subsections 203.04.a. through 203.04.c. of this rule. ~~*(7-1-98)*~~(7-1-03)T

~~***05. Refusal Or Failure To Provide SSN**. Refusal or failure, without good cause, to provide an SSN will end benefits of the person without an SSN. Refusal or failure, without good cause, to apply for an SSN, will end benefits of the person without an SSN. The person is not eligible until an SSN is provided or application is made. The disqualified person's income and resources must be counted in the Food Stamp budget. Explain these penalties to the household. If benefits are reduced or ended, because one (1) or more persons fail to meet the SSN requirement, send a Notice of Decision. The notice includes the name of the disqualified household member, the reason and the new household benefit. The notice tells the household the actions they must take to get Food Stamps for the disqualified member.* *(6-1-94*)~~

0~~6~~4. Good Cause For Not Applying For SSN. If a household member can show good cause why an SSN application was not completed~~*, within the application month*~~ in a timely manner, ~~*the member can participate for an additional month*~~ an extension must be granted to allow him to receive Food Stamp benefits for one month in addition to the month of application. Good cause for failure to apply must be shown monthly in order for such a household member to continue to participate. Good cause is described below: ~~*(6-1-94)*~~(7-1-03)T

a. Good cause exists if the ~~*HW 0446 or other documents show the household submitted form SS-5 to the SSA, but the SS-5*~~ application for SSN was not processed in a timely manner by the SSA. ~~*Once the SS-5 has been filed and accepted by the SSA, the member can be eligible until the SS-5 is processed.*~~ ~~*(6-1-94)*~~(7-1-03)T

b. Good cause exists if documents or collateral data show the household applied for, or made every effort to apply for, an SSN. (6-1-94)

c. Good cause does not include household-caused delays due to illness, lack of transportation, or temporary absences. (6-1-94)

05. Exception For Religious Objection. The Department may assign an identification number to a person who is applying for Food Stamps, but who, because of well-established religious objections as defined under 42 CFR 435.910, refuses to obtain an SSN. The identification number may be either an SSN obtained by the Department on the applicant's behalf or another unique identifier. (7-1-03)T

~~***07. Person Unable To Get Proof For SSA**. If the person is unable to get the proof required by SSA for an SSN, the Department will help the person get proof.* *(6-1-94)*~~

~~***08. Good Cause Extension**. If the person cannot get an SSN in the application month, and good cause exists, a one (1) month extension must be granted to allow the person to get Food Stamps until the SSN is received.*~~

~~*(6-1-94)*~~

~~***09. SSN Proof Required**. Verify all SSNs, or application for SSNs, for each household member. SSNs are proved through Numident. (6-1-94)*~~

~~***10. SSN Not Proved Due To Numident Discrepancy**. If there is a Numident discrepancy take the action listed below: (6-1-94)*~~

~~***a.** Notify household member. Notify the household member, in writing, they must submit a corrected SS-5 and supporting data to SSA within ten (10) calendar days. Notify the household member their Food Stamps will end if the Department does not have proof the SS-5 was submitted to SSA within ten (10) calendar days. (3-15-02)*~~

~~***b.** Evaluate good cause. Determine whether there is good cause for refusal to cooperate, if a household member claims they cannot submit the SS-5 and supporting data to SSA. If the supporting data has been destroyed good cause may exist. (3-15-02)*~~

~~***c.** End benefits. Disqualify only the persons with a Numident discrepancy, who refuse to cooperate with the SSN requirement. Close the case after advance notice, if the entire household has a Numident discrepancy and refuses to cooperate with the SSN requirement. Refusal to cooperate means failure or refusal to submit the SS-5 and required proof to SSA, without good cause. (3-15-02)*~~

~~***204. CITIZENSHIP OR SATISFACTORY IMMIGRATION STATUS.***~~
~~*A person must be a U. S. resident to get Food Stamps. A person must be a U.S. citizen, a U.S. non-citizen national, or a qualified legal non-citizen to get Food Stamps. To be eligible for Food Stamps, legal non-citizens must meet a category in Subsections 204.01 through 204.11 of this rule. (10-1-02)T*~~

~~***01. Permanent Residents**. A non-citizen lawfully admitted to the United States for permanent residence is eligible indefinitely if meeting a condition in Subsection 204.01.a. or 204.01.b. of these rules: (10-1-02)T*~~

~~***a.** The non-citizen is a veteran honorably discharged for a reason other than alienage, or is on active duty in the U.S. Armed Forces for other than training, or is the spouse or unmarried dependent of a veteran or person on active duty. (10-1-02)T*~~

~~***b.** The non-citizen has forty (40) quarters of work. A quarter worked by the legal non-citizen's parent, while the legal non-citizen was under age eighteen (18) and a quarter worked by the legal non-citizen's spouse during marriage if the legal non-citizen remains married to the spouse or the spouse is deceased can be counted as a quarter of work for the legal non-citizen. Any quarter after January 1, 1997, in which a legal non-citizen received any Federal means-tested benefit is not counted as a quarter of work. (3-15-02)*~~

~~***02. Lawful Non-Citizen, Permanent Residents Residing In The U.S. On August 22, 1996**. Lawful non-citizen, permanent residents residing in the U. S. on August 22, 1996 who are: (4-5-00)*~~

~~***a.** Sixty-five (65) years of age or older, at that time; or (4-5-00)*~~

~~***b.** A child who is now under the age of eighteen (18). (4-5-00)*~~

~~***03. Lawful Non-Citizen, Permanent Residents Who Are Blind Or Disabled**. Lawful non-citizen, permanent residents who are blind or disabled and meet one (1) of the disability criteria listed in Subsections 216.02 through 216.10 of these rules. (10-1-02)T*~~

~~***04. Refugees**. A refugee admitted under Section 207 of the Immigration and Nationality Act, a Cuban/Haitian entrant as defined in Section 501(e) of the Refugee Assistance Act of 1980, or an Amerasian admitted under Section 584 of Public Law 100-202 and amended by Public Law 100-461, is eligible: (10-1-02)T*~~

~~***a.** For seven (7) years from refugee's date of entry; or (4-5-00)*~~

~~***b.*** *With no time limit if the refugee is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* *(10-1-02)T*~~

~~***05.*** ***Asylees****. An asylee admitted under Section 208 of the Immigration and Nationality Act is eligible:* *(7-1-99)*~~

~~***a.*** *For seven (7) years from the date asylee status is assigned; or* *(4-5-00)*~~

~~***b.*** *With no time limit if the asylee is a veteran honorably discharged for a reason other than alienage, or on active duty for other than training in the U.S. Armed Forces, or the spouse or unmarried dependent of the veteran or person on active duty.* *(10-1-02)T*~~

~~***06.*** ***Deportation Withheld****. An individual whose deportation has been withheld under Section 241(b)(3) or 243(h) of the Immigration and Nationality Act is eligible:* *(7-1-99)*~~

~~***a.*** *For seven (7) years from the date deportation was withheld; or* *(4-5-00)*~~

~~***b.*** *With no time limit if the deportee is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* *(10-1-02)T*~~

~~***07.*** ***Conditional Entrants****. A conditional entrant admitted under Section 203(a)(7) of the Immigration and Nationality Act who is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* *(10-1-02)T*~~

~~***08.*** ***Parolees****. A person paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one (1) year who is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* *(10-1-02)T*~~

~~***09.*** ***Battered Non-Citizen****. A legal non-citizen admitted to the United States as a battered non-citizen under Section 204(a)(1)(A), or 204(a)(1)(B) of the Immigration and Nationality Act (INA), as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA who is a veteran honorably discharged for a reason other than alienage, or on active duty in the U.S. Armed Forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* *(10-1-02)T*~~

~~***10.*** ***Certain Hmong and Highland Laotians****. Certain Hmong and Highland Laotians who were:* *(4-5-00)*~~

~~***a.*** *Members of a Hmong or Highland Laotian tribe at the time the tribe rendered assistance to United States personnel by taking part in a military or rescue operation during the Vietnam era beginning August 5, 1964 and ending May 7, 1975; or* *(4-5-00)*~~

~~***b.*** *The spouse or unmarried dependent child of such an individual; or* *(4-5-00)*~~

~~***c.*** *The unremarried surviving spouse of such an individual who is deceased.* *(4-5-00)*~~

~~***11.*** ***Native Americans****. Native Americans with treaty rights to cross the U.S. borders, American Indians born in Canada to whom the provisions of Section 289 of the Immigration and Nationality Act apply, or members of an Indian tribe as defined in Section 4(e) of the Indian Self-Determination and Education Assistance Act.* *(4-5-00)*~~

204. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.

To be eligible for Food Stamps, an individual must be a member of one (1) of the groups listed in Subsections 204.01 through 204.14 of this rule. (4-1-03)T

01. **U.S. Citizen**. A U.S. Citizen; or (4-1-03)T

02. **U.S. National**. A U.S. National; or (4-1-03)T

03. **Full-Time Active Duty U.S. Armed Forces Member**. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who is currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member; or (4-1-03)T

04. **Veteran Of The U.S. Armed Forces**. A qualified non-citizen as defined in 8 U.S.C. 1641 (b) or (c) who was honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran; or (4-1-03)T

05. **Refugees And Others Fleeing Persecution**. A non-citizen who was: (4-1-03)T

a. Admitted into the U.S. as a refugee under 8 U.S.C. 1157 (including those who have adjusted to lawful permanent resident status); or (4-1-03)T

b. Granted asylum under 8 U.S.C. 1158 (including those who have adjusted to lawful permanent resident status); or (4-1-03)T

c. Granted withholding of deportation or removal under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208 (including those who have adjusted to lawful permanent resident status); or (4-1-03)T

d. Admitted into the U.S. as an Amerasian immigrant under Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in Section 101(e) of Public Law 100-202 and amended by the 9th proviso under migration and refugee assistance in Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended); or (4-1-03)T

e. Granted status as a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Assistance Act of 1980 (including those who have adjusted to lawful permanent resident status); or (4-1-03)T

06. **Qualified Non-Citizen For At Least Five Years**. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), who has had a qualified non-citizen status for at least five (5) years; or (4-1-03)T

07. **Lawful Permanent Resident (LPR) with Forty Quarters Of Work History**. A lawful permanent resident (LPR) who has forty (40) quarters of work history under Title II of the Social Security Act, or can be credited with that work history under 8 U.S.C. 1645; or (4-1-03)T

08. **Qualified Non-Citizens Receiving Disability-Related Assistance**. Qualified non-citizens, as defined in 8 U.S.C. 1641(b) or (c), who are receiving benefits or assistance for blindness or disability (within the meaning of Section 3(r) of the Food Stamp Act of 1977 (7 U.S.C. 2012(r))); or (4-1-03)T

09. **Qualified Non-Citizen Children**. Qualified non-citizens, as defined in 8 U.S.C. 1641(b) or (c), who are under age eighteen (18) are eligible for food stamps regardless of their date of entry into the United States; or (10-1-03)T

10. **Qualified Non-Citizen Seniors**. Qualified non-citizens, as defined in 8 U.S.C. Section 1641(b) or (c), who on August 22, 1996 were age sixty-five (65) or over and were lawfully residing in the United States; or (4-1-03)T

11. **American Indian Born In Canada**. An American Indian born in Canada under 8 U.S.C. 1359; or (4-1-03)T

12. **American Indian Born Outside The U.S.** An American Indian born outside of the U.S., and is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e); or (4-1-03)T

13. **Certain Hmong And Highland Laotians**. Hmong and Highland Laotians who were: (4-1-03)T

a. Members of a Hmong or Highland Laotian tribe at the time the tribe rendered assistance to United States personnel by taking part in a military or rescue operation during the Vietnam era beginning August 5, 1964 and ending May 7, 1975; or (4-1-03)T

b. The spouse or unmarried dependent child of such an individual; or (4-1-03)T

c. The unremarried surviving spouse of such an individual who is deceased; or (4-1-03)T

14. **Victim Of Severe Form Of Trafficking**. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13), who meets one (1) of the following: (4-1-03)T

a. Is under the age of eighteen (18) years; or (4-1-03)T

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (4-1-03)T

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (4-1-03)T

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (4-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

218. PERSONS DISQUALIFIED AS FOOD STAMP HOUSEHOLD MEMBERS.
Persons disqualified as Food Stamp household members must not participate in the Food Stamp program. Disqualified household members are not counted in the household size. Disqualified household members' income and resources are counted. Disqualified household members are listed below: (6-1-94)

01. **Ineligible Legal Non-Citizen**. Ineligible legal non-citizens not meeting citizenship or eligible legal non-citizen requirements. (7-1-98)

02. **Persons With Citizenship Questionable**. Persons refusing to sign a declaration attesting to citizenship or legal non-citizen status. (7-1-98)

03. **Person Refusing SSN**. Persons disqualified for failure or refusal to provide a Social Security Number. (6-1-94)

04. **JSAP Or Work Registration Noncompliance**. Persons disqualified for failure to comply with JSAP or work registration requirements. (4-5-00)

05. **Persons With IPV**. Persons disqualified for an Intentional Program Violation (IPV). (6-1-94)

06. **Voluntary Quit Or Reduction Of Hours Of Work**. Persons disqualified for a voluntary quit or reduction in hours of work. (4-5-00)

07. **ABAWD Not Meeting Work Requirement**. Persons who have received three (3) months of Food Stamp benefits in a three (3) year period without meeting the ABAWD work requirement. (7-1-98)

08. **Fugitive Felon**. ~~*Persons who are determined to be a fugitive felon or probation or parole violator.*~~ Individuals who are fleeing to avoid prosecution or custody for a crime, or an attempt to commit a crime, that would be classified as a felony (or in the State of New Jersey, a high misdemeanor) or who are violating a condition of

probation or parole under a federal or state law. ~~*(7-1-98)*~~(7-1-03)T

09. Drug Convicted Felon. Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use or distribution of a controlled substance when they do not comply with the terms of a withheld judgment, probation or parole. The felony must have occurred after August 22, 1996. (3-30-01)

10. Failure To Cooperate In Paternity Establishment Or Obtaining Support. Persons disqualified for failure to cooperate in establishing paternity and obtaining support for a child under eighteen (18). (7-1-98)

(BREAK IN CONTINUITY OF SECTIONS)

251. ABLE BODIED ADULTS WITHOUT DEPENDENTS (ABAWD) WORK REQUIREMENT.
To participate in the Food Stamp program, a person must meet one (1) of the conditions in Subsections 251.01 through 251.05 of this rule. A person who does not meet one (1) of these conditions may not participate in the Food Stamp program as a member of any household for more than three (3) full months (consecutive or otherwise) in the thirty-six (36) month period beginning December 1, ~~*1999*~~ 2002 and ending November 30, 200~~2~~5. ~~*(5-3-03)*~~(12-1-02)T

01. Work At Least Eighty Hours Per Month. The person must work at least eighty (80) hours per month. The definition of work under Section 251 of this rule is any combination of: (5-3-03)

a. Work in exchange for money. (3-15-02)

b. Work in exchange for goods or services, known as “in-kind” work. (3-15-02)

c. Unpaid work, with a public or private non-profit agency. (3-15-02)

02. Participate In JSAP Or Another Work Program. The person must participate in and comply with the requirements of the JSAP program (other than job search or job readiness activities), the WIA program, a program under Section 236 of the Trade Act of 1974, or another work program recognized by the Department. The person must participate for at least eighty (80) hours per month. (3-15-02)

03. Combination Of Work And Work Programs. The person must work and participate in a work program. Participation in work and work programs must total at least eighty (80) hours per month. (3-15-02)

04. Participate In Work Opportunities. The person must participate in and comply with the requirements of a Work Opportunities program. (7-1-99)

05. Residents Of High Unemployment Areas. ABAWDs residing in a county identified as having high unemployment or lack of jobs are not subject to the three (3) month limitation of benefits. ABAWDs residing in these counties are subject to JSAP work requirement but will not lose Food Stamp eligibility after three (3) months if they participate fewer than eighty (80) hours per month. An ABAWD residing in a high unemployment area must participate according to ~~*their*~~ his plan. ~~*(5-3-03)*~~(7-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

401. EARNED INCOME.
Earned income includes, but is not limited to, income listed in Section 401. (3-15-02)

01. Wages Or Salary. Wages and salaries of an employee, advances, tips, commissions, meals, and military pay are earned income. Garnishments from wages are earned income. (6-1-94)

02. Self-Employment Income. Income from self-employment, including capital gains, is earned income. Rental property is a self-employment enterprise. The income is earned if a household member manages the

property an average of twenty (20) or more hours per week. Payment from a roomer or boarder is self-employment income. (6-1-94)

03. Training Allowances. Training allowances from programs such as ~~*Work Study, and*~~ Vocational Rehabilitation are earned income. ~~*(7-1-99)*~~(7-1-03)T

04. Payments Under Title I. Payments under Title I, such as VISTA and University Year for Action under P.L. 93-113 are earned income. (6-1-94)

05. On-The-Job Training Programs. WIA income includes monies paid by WIA or the employer. Income from WIA on-the-job training programs is earned income, unless paid to a household member under age nineteen (19). The household member under age nineteen (19) must be under the control of another household member. (3-15-02)

06. Basic Allowance For Housing (BAH). BAH is an Armed Services housing allowance. BAH is counted as earned income. (4-5-00)

(BREAK IN CONTINUITY OF SECTIONS)

405. EXCLUDED INCOME.
Income excluded when computing Food Stamp eligibility is listed below: (6-1-94)

01. Money Withheld. Money withheld voluntarily or involuntarily, from an assistance payment, earned income, or other income source, to repay an overpayment from that income source, is excluded. If an intentional noncompliance penalty results in a decrease of benefits under a means tested program such as SSI or GA, count that portion of the benefit decrease attributed to the repayment as income. (7-1-98)

02. Child Support Payments. Child support payments received by TAFI recipients which must be given to CSS are excluded as income. (7-1-98)

03. Earnings Of Child Under Age Eighteen Attending School. Earned income of a household member under age eighteen (18) is excluded. The member must be under parental control of another household member and attending elementary or secondary school. For the purposes of this provision, an elementary or secondary student is someone who attends elementary or secondary school or who attends GED or home-school classes that are recognized, operated, or supervised by the school district. This exclusion applies during semester and summer vacations if enrollment will resume after the break. If the earnings of the child and other household members cannot be differentiated, prorate equally among the working members and exclude the child's share. (7-1-98)

04. Retirement Benefits Paid To Former Spouse Or Third Party. Social Security retirement benefits based on the household member's former employment, but paid directly to an ex-spouse, are excluded as the household member's income. Military retirement pay diverted by court order to a household member's former spouse is excluded as the household member's income. Any retirement paid directly to a third party from a household member's income by a court order is excluded as the household member's income. (6-1-94)

05. Infrequent Or Irregular Income. Income received occasionally is excluded as income if it does not exceed thirty dollars ($30) total in a three (3) month period. (6-1-94)

06. Cash Donations. Cash donations based on need and received from one (1) or more private nonprofit charitable organizations are excluded as income. The donations must not exceed three hundred dollars ($300) in a calendar quarter of a federal fiscal year (FFY). (6-1-94)

07. Income In Kind. Any gain or benefit, such as meals, garden produce, clothing, or shelter, not paid in money, is excluded as income. (6-1-94)

08. Vendor Payments. ~~*Vendor payments are monies not legally obligated to the household. Vendor payments are paid directly to a third party by a non-household member. Vendor payments include, but are not limited*~~

~~to:~~ A vendor payment is a money payment made on behalf of a household by a person or organization outside of the household directly to either the household's creditors or to a person or organization providing a service to the household. ~~(6-1-94)~~(7-1-03)T

~~**a.** *Housing or rent paid by an employer to a third party when the housing is in addition to obligated wages.* (6-1-94)~~

~~**b.** *Payments to a third party for a household expense. The payments must be made by a nonhousehold member not legally bound to pay.* (6-1-94)~~

~~**c.** *Vendor payments for transitional housing for the homeless are not excluded as income.* (7-1-98)~~

09. **Third Party Payments**. If a person or organization makes a payment to a third party on behalf of a household using funds that are not owed to the household, the payment shall be excluded from income. (7-1-03)T

~~**09**~~**10.** **Loans**. Loans are money received which is to be repaid. Loans are excluded as income. (6-1-94)

1~~0~~1. **Money For Third Party Care**. Money received and used for the care and maintenance of a third party who is not in the household. If a single payment is for both household members and nonhousehold members the identifiable portion of the payment for nonhousehold members is excluded. If a single payment is for both household members and nonhousehold members, exclude the lesser of: (6-1-94)

a. The prorated share of the nonhousehold members if the portion cannot be identified. (6-1-94)

b. The amount actually used for the care and maintenance of the nonhousehold members. (6-1-94)

1~~1~~2. **Reimbursements**. Reimbursements for past or future expenses not exceeding actual costs. Payments must not represent a gain or benefit. Payments must be used for the purpose intended and for other than normal living expenses. Excluded reimbursements are not limited to: (6-1-94)

a. Travel, per diem, and uniforms for job or training. (6-1-94)

b. Out-of-pocket expenses of volunteer workers. (6-1-94)

c. Medical and dependent care expenses. (6-1-94)

d. Pay for services provided by Title XX of the Social Security Act. (6-1-94)

e. Repayment of loans made by the household from their personal property limit. The repayment must not exceed the amount of the loan. (6-1-94)

f. Work-related and dependent care expenses paid by the JSAP program. (6-1-94)

g. Transitional child care payments. (6-1-94)

h. Child care payments under the Child Care and Dependent Block Grant Act of 1990. (6-1-94)

1~~2~~3. **Federal Earned Income Tax Credit (EITC)**. Federal EITC payments are excluded as income. (9-1-94)

14. **Work Study**. Work Study income received while attending post-secondary school is excluded as income. (7-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

537. DEPENDENT CARE RESTRICTIONS.
Dependent care restrictions are listed below: (6-1-94)

01. Care By Household Member. Dependent care cannot be deducted if the care is provided by another household member. (6-1-94)

02. In-Kind Payment. Dependent care cannot be deducted if the payment is in-kind, such as food or exchanges for shelter. (6-1-94)

03. Vendor Payment. Dependent care cannot be deducted if paid by vendor payment. (6-1-94)

04. Education Exclusion. Dependent care cannot be deducted if income for dependent care is excluded from educational income. (6-1-94)

05. Spouse Can Give Care. Dependent care cannot be deducted if the spouse in the home is physically capable of the dependent care and is not working, seeking work, or registered for work. (6-1-94)

06. Paid Or Reimbursed Dependent Care ~~Repaid~~. Dependent care cannot be deducted if ~~repaid~~ paid or reimbursed under a ~~F~~federal child care program. ~~Federal programs include At Risk, Child Care Development Block Grant Act of 1990, Transitional Child Care Program, or Title IV-A of the Social Security Act child care payments.~~ ~~(6-1-94)~~(7-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

616. DECREASES OR CLOSURE OF FOOD STAMPS.
If a change results in a decrease or closure of Food Stamps, the Department must provide notice. ~~The notice must be sent within ten (10) days of the date the change is reported.~~ The change must be effective the first month following timely notice, unless the change does not require ten (10) day advance notice. If the household does not respond to the request for proof, or does respond but refuses to provide sufficient information or fails to provide required proof of a change affecting eligibility by the requested date, send a closure notice. The notice must explain the reason for the closure. The notice must advise the household of the need to submit a new application if it wishes to continue participating in the program. If the household fails to provide required proof of a change affecting Food Stamp amount by the requested date, and the change would result in decreased benefits, no deduction is allowed or benefits are decreased. If the household provides the change verification after the date requested, act on the change as if it was an increase. The effective date of the change is the month after the month the change is verified. ~~(3-15-02)~~(7-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

753. SPONSORED LEGAL NON-CITIZENS.
Sponsored legal non-citizens are lawfully admitted for permanent United States residence, as defined in Sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act. A sponsor executes an I-864 affidavit of support ~~or similar agreement~~ on behalf of legal non-citizen, as a condition of the legal non-citizen's entry or admission into the United States as a permanent resident. The income and resources of the sponsor will be deemed until the legal non-citizen becomes a naturalized citizen or until he has worked forty (40) qualifying quarters of coverage under Title II of the Social Security Act, or the sponsor dies. A qualifying quarter includes a quarter worked by the legal non-citizen's parent while the legal non-citizen was under eighteen (18) and a quarter worked by the legal noncitizen's spouse during marriage if the legal non-citizen remains married to the spouse or the spouse is deceased. Any quarter after January 1, 1997 in which a legal non-citizen received any ~~F~~federal means-tested benefit is not counted as a qualifying quarter. ~~(3-15-02)~~(4-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

756. EXCEPTIONS TO SPONSOR DEEMING.
Exceptions to sponsor deeming are listed in Subsections 756.01 through 756.03 of this rule. ~~(3-15-02)~~(4-1-03)T

01. Legal Non-Citizen Whose Sponsor Signed An Affidavit Of Support. A legal non-citizen whose sponsor signed an affidavit of support is exempt from deeming if he meets at least one (1) of the following conditions: ~~(3-15-02)~~(4-1-03)T

a. The legal non-citizen is a member of the sponsor's Food Stamp household~~.~~; or ~~(7-1-99)~~(4-1-03)T

b. The legal non-citizen is sponsored by an organization or group~~.~~; or ~~(7-1-99)~~(4-1-03)T

c. The legal non-citizen has become a U.S. citizen or naturalized citizen; or (4-1-03)T

d. The legal non-citizen's sponsor did not sign affidavit of support Form I-864; or (4-1-03)T

e. The legal non-citizen has worked or can get credit for forty (40) quarters of work, including quarters earned by a parent or spouse; or (4-1-03)T

f. The legal non-citizen's sponsor is deceased; or (4-1-03)T

~~e~~g. The legal non-citizen is not required to have a sponsor under the Immigration and Nationality Act. This includes a refugee, asylee, deportee, parolee or Cuban or Haitian entrant~~.~~; or ~~(7-1-99)~~(4-1-03)T

h. The legal non-citizen is a child under the age of eighteen (18). (10-1-03)T

02. Battered Legal Non-Citizen Whose Sponsor Signed An Affidavit Of Support. For sponsor deeming, a battered legal non-citizen includes the non-citizen and the child of the non-citizen. The non-citizen or child must be battered in the U.S. by a spouse, parent, or member of the family in the same household. The non-citizen must not participate in, or acquiesce to, the battering of the child. (3-15-02)

a. A battered legal non-citizen whose sponsor signed an affidavit of support is exempt from the sponsor deeming requirement for one (1) year, if the need for Food Stamps is connected to the battery and the legal non-citizen no longer lives with the batterer. (3-15-02)

b. The exemption from the sponsor deeming requirement can exceed more than one (1) year if the legal non-citizen demonstrates the battery has been recognized in an order of a judge or by the INS and the need for Food Stamps is connected to the battery. (7-1-99)

03. Indigent Legal Non-Citizen Whose Sponsor Signed An Affidavit Of Support. A non-citizen is indigent if ~~*the Department determines he is unable to obtain food and shelter without receiving Food Stamps*~~ the household income does not exceed one-hundred thirty percent (130%) of the poverty income guideline (gross income limit) for the household size. (4-1-03)T

a. For an indigent non-citizen, the Department counts ~~*only*~~ the noncitizen's own income and the cash or in-kind income and resources actually provided by the sponsor and spouse who signed an affidavit of support. ~~*Only actual income and resources are counted for one (1) year after the indigent determination is made.*~~ ~~(3-15-02)~~(4-1-03)T

b. A legal non-citizen that satisfies the indigent exemption criteria is exempt from deeming for twelve (12) months. The exemption can be renewed for additional twelve-month periods. (4-1-03)T

c. If a legal non-citizen is granted an indigence exemption, the department must provide written notification to the Statistics Branch of the INS on an annual basis. Required information includes, written notice of the determination , the sponsored legal non-citizen's name, and the sponsor's name. (4-1-03)T

d. A legal non-citizen can elect to decline the indigent exemption to avoid sponsor liability, and notification to the INS. (4-1-03)T

e. If the legal non-citizen declines the indigent exemption, the household is subject to sponsored

deeming. (4-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

760. OVERISSUANCE DUE TO INCORRECT SPONSOR DATA.
The sponsor who signed an I-864 affidavit of support ~~*between February 1, 1983 and*~~ on or after December 1~~8~~9, 1997 and sponsored legal non-citizen are both liable for repayment of overissuances caused by incorrect sponsor data, unless the sponsor had good cause. Good cause exists unless the sponsor gives false statements or willfully withholds data. The sponsor may have a fair hearing to contest the fault and liability. If the sponsor had good cause or was without fault for incorrect data, the legal non-citizen's household is solely liable for the overissuance repayment. If the sponsor did not have good cause, start a claim against the sponsor, the legal non-citizen's household, or both. Claims may be started against both parties at the same time. ~~*Start a*~~ A claim may be started against the party most likely to repay the claim first. If the first party fails to respond to the demand letter within twenty (20) days, ~~*start*~~ a claim may be started against the other party. ~~*Identify t*~~The claim must be identified as either an IHE or IPV claim. ~~*(7-1-99)*~~(4-1-03)T

761. COLLECTING CLAIMS AGAINST SPONSORS WHO SIGNED AN I-864 AFFIDAVIT OF SUPPORT ~~*BETWEEN FEBRUARY 1, 1983 AND*~~ ON OR AFTER DECEMBER 1~~8~~9, 1997.
~~*Start collection by sending*~~ The Department must send a demand letter to the sponsor. The demand letter must include the amount owed, the reason for the claim, and the repayment options. The demand letter must tell the sponsor he will not have to repay, if he can show he did not give false statements or withhold information about his circumstances. Collection action may be stopped if documentation is obtained showing the sponsor cannot be located. Collection action may be stopped if the cost of collection exceeds the amount to be recovered. If the sponsor responds to the demand letter, ~~*collect*~~ a lump sum cash payment may be collected if the sponsor can pay the claim at one (1) time. If the sponsor cannot pay by lump sum, ~~*negotiate*~~ a monthly repayment schedule may be negotiated. Sponsor repayments must be recorded in the case file and identified as either an IHE or IPV claim. ~~*(7-1-99)*~~(4-1-03)T

762. COLLECTING CLAIMS AGAINST SPONSORED LEGAL NON-CITIZENS.
~~*Collect c*~~Claims may be collected against sponsored legal non-citizens with a sponsor who signed an I-864 affidavit of support ~~*between February 1, 1983 and*~~ on or after December 1~~8~~9, 1997~~*using procedures listed below*. *Take a*~~Action may be taken to collect~~*, whether or not the legal non-citizen household currently gets Food Stamps*~~ by submitting an IHE or IPV. ~~*(7-1-99)*~~(4-1-03)T

~~***01. IHE Determined**. An IHE results if information provided about the sponsor or sponsor's spouse was wrong because the household misunderstood or failed to provide data. Start a claim against the legal non-citizen's household.* *(7-1-98)*~~

~~***02. IPV Determined**. An IPV results if information provided about the sponsor or sponsor's spouse was incorrect because the household concealed or provided false information. Start a claim against the legal non-citizen's household.* *(7-1-98)*~~

~~***03. IPV Referral**. Pursue an IPV if enough evidence exists to show information from the sponsor or the sponsor's spouse was false or concealed through misrepresentation or willful withholding by the legal non-citizen. Handle the claim as an IHE until the IPV decision is made. Start a claim against the legal non-citizen's household.* *(7-1-98)*~~

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0203

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is October 1, 2002. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section 56-1004(1), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Subsection 106.03.c. is being deleted because it duplicated a requirement that was covered in Subsection 106.01.b. and the subsection is not necessary.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the December Idaho Administrative Bulletin, Volume 02-12, pages 61 through 66.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Maggie Manzo, (208) 334-5753.

DATED this 17th day of January, 2003.

Sherri Kovach
Administrative Procedures Coordinator
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IDAPA 16, TITLE 03, CHAPTER 05

RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 02-12, December 4, 2002, pages 61 through 66.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0305-0203

SUBSECTION 106.03.b. and 106.03.c.

106. CITIZENSHIP AND LEGAL NON-CITIZEN REQUIREMENT.
Individuals must be U.S. citizens or nationals or qualified legal non-citizens to be eligible. Nationals of American Samoa or Swain's Island are the equivalent of U.S. citizens. Only groups of legal non-citizens listed in Subsections 106.01 through 106.09 may be eligible. (7-1-99)

03. Permanent Residents Admitted On Or After August 22, 1996. A lawful permanent resident admitted on or after August 22, 1996 must: (10-1-02)T

a. Be a veteran honorably discharged for a reason other than alienage or is on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or (10-1-02)T

b. Have lived in the U.S. for at least five (5) years and ha~~s~~ve forty (40) quarters of work~~*: or*~~. ~~*(10-1-02)T*~~(10-1-02)T

~~***c.*** *Be blind or disabled of any age under the SSI disability criteria.* *(10-1-02)T*~~

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED

DOCKET NO. 16-0305-0203

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective October 1, 2002, and January 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-1004(l), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 18, 2002.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

The requirement for a face-to-face interview is being changed to a telephone interview. Medicaid coverage for certain eligible disabled aliens is being added. Clarification is being made for the definition of "room and board". Clarification is being made to provide a participant must require or is likely to require waiver services as a condition of eligibility for Home and Community Based Services. Clarification to provide that income and resource exclusions for AABD program are used for eligibility determinations effective January 1, 2003, for both Qualified Medicare Beneficiary (QMB) eligibility and for Specified Low Income Medicare Beneficiary (SLMB) eligibility. Effective January 1, 2003, the SLBM III group is being eliminated.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(b), Idaho Code and are necessary in order to comply with federal regulations.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are being made due to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Maggie Manzo at (208) 334-5753.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before December 25, 2002.

DATED this 11th day of October, 2002.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
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(208) 334-5564 phone, (208) 332-7347 fax
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THE FOLLOWING IS THE TEXT OF DOCKET 16-0305-0203

052. PERSONAL INTERVIEW.
Each applicant for AABD must participate in a ~~*face-to-face*~~ telephone interview unless good cause exists. Upon request, the Department may require a face-to-face interview. ~~*(7-1-99)*~~(10-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

106. CITIZENSHIP AND LEGAL NON-CITIZEN REQUIREMENT.
Individuals must be U.S. citizens or nationals or qualified legal non-citizens to be eligible. Nationals of American Samoa or Swain's Island are the equivalent of U.S. citizens. Only groups of legal non-citizens listed in Subsections 106.01 through 106.09 may be eligible. (7-1-99)

01. Permanent Residents Admitted Before August 22, 1996. Participants must be: (7-1-99)

a. For AABD cash, legal non-citizens lawfully admitted for permanent residence and getting AABD on August 22, 1996. For Medicaid, legal non-citizens lawfully admitted for permanent residence. (7-1-99)

b. Legal non-citizens of any age who are blind or disabled under the SSI disability criteria and lawfully admitted for permanent residence. (7-1-99)

c. American Indians born in Canada to whom Section 289 of the INA applies or legal non-citizens who are members of Indian tribes. (7-1-99)

d. Legal non-citizens who started AABD or SSI before January 1, 1979. (7-1-99)

02. Battered Non-Citizen Admitted Before August 22, 1996. A legal non-citizen admitted to the U.S. before August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A) or 204(a)(1)(B) of the INA, as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA who is: (7-1-99)

a. A veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or (7-1-99)

b. Blind or disabled of any age under the SSI disability criteria and lawfully admitted for permanent residence; or (7-1-99)

c. Lawfully admitted for permanent residence and getting AABD. (7-1-99)

03. Permanent Residents Admitted On Or After August 22, 1996. A lawful permanent resident admitted on or after August 22, 1996 must ~~*be*~~: ~~*(7-1-99)*~~(10-1-02)T

a. Be ~~*A*~~a veteran honorably discharged for a reason other than alienage or is on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or ~~*(7-1-99)*~~(10-1-02)T

b. Have lived in the U.S. for at least five (5) years and has forty (40) quarters of work~~.~~; or ~~*(7-1-99)*~~(10-1-02)T

c. Be blind or disabled of any age under the SSI disability criteria. (10-1-02)T

04. Battered Non-Citizen Admitted On Or After August 22, 1996. A legal non-citizen admitted to the U.S. on or after August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A) or 204(a)(1)(B) of the INA, or as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA, who is: (7-1-99)

a. A veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or (7-1-99)

b. Who has lived in the U.S. for at least five (5) years. (7-1-99)

05. Refugees. A refugee admitted under Section 207 of the INA, a Cuban/Haitian entrant as defined in Section 501(e) of the Refugee Assistance Act of 1980, or an Amerasian admitted under Section 584 of Public Law 100-202 and amended by Public Law 100-461 is eligible: (7-1-99)

a. For seven (7) years from the date of entry; or (7-1-99)

b. With no time limit if the refugee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

06. Asylees. An asylee admitted under Section 208 of the INA is eligible: (7-1-99)

a. For seven (7) years from the date asylee status is assigned; or (7-1-99)

b. With no time limit if the asylee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

07. Deportation Withheld. An individual whose deportation has been withheld under Section 241(b)(3) or 243(h) of the INA is eligible: (7-1-99)

a. For seven (7) years from the date deportation was withheld; or (7-1-99)

b. With no time limit if the deportee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

08. Conditional Entrants. A conditional entrant admitted under Section 203(a)(7) of the INA who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

09. Parolees. A person paroled into the U.S. under Section 212(d)(5) of the INA for a period of at least one (1) year, who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

512. ROOM AND BOARD HOME ALLOWANCE.
Room and board is a living arrangement where the participant purchases lodging (room) and meals (board) from a person he lives with who is not his parent, child or sibling. Through December 31, 2000, a participant living in a room and board home is budgeted six hundred thirty-two dollars ($632) monthly. Beginning January 1, 2001, the Room and Board allowance increase is one-half (1/2) the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. Beginning January 1, 2002, the Room and Board allowance increase is the

dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. ~~*(3-15-02)*~~(1-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

787. PERSON ENTITLED TO HOME AND COMMUNITY BASED SERVICES (HCBS).
An aged, blind or disabled person not eligible for SSI or AABD cash in his own home, because of income deeming or income limits, is eligible for Medicaid if he meets the conditions in Subsections 787.01 through 787.12. (7-1-99)

01. Age. Is at least eighteen (18) years old. (4-5-00)

02. AABD Criteria. If under age sixty-five (65), meets the AABD blindness or disability criteria. (7-1-99)

03. AABD Resource Limit. Meets the AABD single person resource limit. (7-1-99)

04. HCBS Income Limit. For the HCBS Aged and Disabled (A&D) waiver, has income not exceeding three (3) times the Federal SSI benefit payable monthly to a single person. For the HCBS Developmentally Disabled (DD) waiver, has income not exceeding three (3) times the Federal SSI benefit payable monthly to a single person. (3-15-02)

05. Eligible For Long Term Care. For HCBS-A&D, meets the medical conditions for nursing facility care in accordance with IDAPA 16.03.09, "Rules Governing Medical Assistance," Subsection 160.09. For HCBS-DD, meets the medical conditions for ICF/MR care in accordance with IDAPA 16.03.09, "Rules Governing Medical Assistance," Section 143. (3-30-01)

06. Maintained In The Community. For HCBS-A&D, can be maintained in the community with A&D waiver services furnished under the Department's HCBS waiver. For HCBS-DD, can be maintained in the community with DD waiver services. (1-1-02)T

07. Cost Of Care. For HCBS-A&D, can be cared for in the community at a cost not to exceed the statewide average cost of care for the participant's level of care. The estimated cost of care in a nursing facility is the statewide average rate for the level of care the participant requires, charged by the type of facility where he would be placed if he were not living at home. For traumatic brain injury patients, the estimated cost of care is at the nursing facility special rate. (1-1-02)T

08. Care Requirement. For HCBS-A&D, must require and receive, or be likely to require and receive, HCBS-A&D waiver services for thirty (30) consecutive days. For HCBS-DD, must require and receive, or be likely to require and receive, HCBS-DD waiver services for thirty (30) consecutive days. (1-1-02)T

09. Effective Date. Medicaid is effective the first day of the thirty (30) day period the participant is likely to require and receive HCBS A&D or HCBS-DD waiver services. The date of the FSI resource assessment is the start date of the first thirty-day (30) period after September 30, 1989, that the participant is likely to require HCBS A&D or HCBS-DD waiver services. ~~*(3-30-01)*~~(1-1-03)T

10. Participant With Spouse. A married participant living at home with his spouse who is not and HCBS participant, can choose between the SSI, CP, and FSI methods. If his spouse is also an HCBS participant or lives in a nursing home, the couple can choose between the SSI and CP methods. (7-1-99)

11. Continued Services. The participant must continue to require and receive waiver services. The participant is ineligible when there is a lapse in need for or receipt of waiver services for thirty (30) days. (7-1-99)

12. Annual Limit. A participant who applies for HCBS Medicaid, after the annual limit on HCBS-A&D or HCBS-DD waiver participants is reached, must be denied Medicaid. (3-30-01)

(BREAK IN CONTINUITY OF SECTIONS)

810. QUALIFIED MEDICARE BENEFICIARY (QMB).
A person meeting all requirements in Subsections 810.01 through 810.07 is eligible for QMB. QMB Medicaid pays Medicare premiums, coinsurance, and deductibles. (3-15-02)

01. Medicare Part A. The participant must be entitled to hospital insurance under Part A of Medicare at the time of his application. (7-1-99)

02. Nonfinancial Requirements. The participant must meet the Medicaid residence, citizenship, support cooperation, and SSN requirements. (7-1-99)

03. Income. Monthly income must not exceed one hundred percent (100%) of the official poverty line defined by the Federal Office of Management and Budget (OMB). The single person income limit is the poverty line for a family of one (1) person. The couple income limit is the poverty line for a family of two (2) persons. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual Federal poverty line revision is published. AABD cash is not counted as income. The income exclusions and disregards used for AABD are used for QMB. ~~*(7-1-99)*~~(10-1-02T

04. Dependent Income. Income of the dependent child, parent, or sibling is not counted. (7-1-99)

05. QMB Dependent Family Member Disregard. A dependent family member is a minor child, adult child meeting SSA disability criteria, parent or sibling of the participant or spouse living with the participant. The family member is or could be claimed on the Federal tax return of the participant or spouse. A participant with a dependent family member has an income disregard based on family size. The spouse is included in family size, whether or not the spouse is also participant. The disregard is based on the official poverty line income as defined by the OMB. The disregard is the difference between the poverty line for one (1) person, or two (2) persons if the participant has a spouse, and the poverty line for the family size including the participant, spouse, and dependent. (7-1-99)

06. Resource Limit. The resource limit for a single participant is four thousand dollars ($4,000). The resource limit for a couple is six thousand dollars ($6,000). The resource exclusions used for AABD are used for QMB. ~~*(7-1-99)*~~(10-1-02)T

07. Effective Dates. The effective date of QMB coverage is no earlier than the first day of the month after the approval month. A QMB participant is not entitled to backdated Medicaid. (7-1-99)

811. SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB).
A person meeting all requirements in Subsections 811.01 through 811.07 is eligible for SLMB. Medicaid pays ~~*all or part of*~~ the Medicare Part B premiums for a SLMB~~*, depending on the participant's SLMB group*~~. The income and resource exclusions and disregards used for AABD are used for SLMB. ~~*(7-1-99)*~~(10-1-02)T

01. Other Medicaid. The SLMB ~~*I*~~ may be eligible for other Medicaid. The SLMB II ~~*and SLMB III*~~ cannot be eligible for any other type of Medicaid. ~~*(7-1-99)*~~(1-1-03)T

02. Medicare Part A. The SLMB must be entitled to hospital insurance under Part A of Medicare at the time of his application. (7-1-99)

03. Nonfinancial Requirements. The SLMB must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation, and SSN. (7-1-99)

04. Income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual Federal poverty line revision is published. The monthly income limit depends on

the SLMB group. The single person limit is based on a family of one (1). The couple limit is based on a family of two (2). The monthly income limit for SLMB Group I is up to one hundred twenty percent (120%) of the Federal poverty line. Monthly income for SLMB Group II is at least one hundred and twenty percent (120%) and not more than one hundred thirty five percent (135%) of the Federal poverty line. ~~*The monthly income limit for SLMB Group III is at least one hundred thirty five percent (135%) and not more than one hundred seventy five percent (175%) of the Federal poverty line.*~~ ~~*(7-1-99)*~~(1-1-03)T

05. **Resource Limit**. The resource limit for a single person is four thousand dollars ($4,000). The resource limit for a couple is six thousand dollars ($6,000). (7-1-99)

06. **Coverage Limits**. Medicaid pays the Medicare Part B premium for SLMB Group I. There is no annual limit on participants served. Medicaid pays the Medicare Part B premium for SLMB Group II. There is an annual limit on participants served, based on availability of Federal funds. New applications are denied when the annual limit is reached. ~~*Medicaid pays part of the Medicare Part B premium for SLMB Group III. The Medicaid payment is the increase in the Part B premium described in Section 4732 of Public Law 105-33. New applications are denied when the annual limit is reached.*~~ ~~*(7-1-99)*~~(1-1-03)T

07. **Effective Dates**. SLMB coverage begins on the first day of the application month. SLMB coverage may be backdated up to three (3) calendar months before the application month. (7-1-99)

08. **Status Of SLMB Group II**. SLMB Group II is extended to at least January 21, 2003, pending action by the U. S. Congress. (1-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED

DOCKET NO. 16-0305-0301

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is April 1, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section 56-1004(1), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The temporary rule and the pending rule are being amended to address comments that were received during the public comment peiod of the proposed rulemaking. The Department is deleting the Subsection 106.07 because it may not require legal permanent residents to have forty (40) quarters of work to be eligible for benefits.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes different from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the August Administrative Bulletin, Volume 03-8, pages 58 through 61.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Maggie Manzo at (208) 334-5753.

DATED this 29th day of September, 2003.

Sherri Kovach
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IDAPA 16, TITLE 03, CHAPTER 05

RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-8, August 6, 2003, pages 58 through 61.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET 16-0305-0301

SUBSECTIONS 106.07 through 106.14 (Partial Section)

106. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible, an individual must be a member of one (1) of the groups listed in Subsections 106.01 through 106.1~~4~~3 of this rule. ~~*(4-1-03)T*~~(4-1-03)T

~~***07. Legal Permanent Resident (LPR) Entering On Or After August 22, 1996**. A legal permanent resident (LPR) entering the U.S. on or after August 22, 1996, who has been living in the U.S. for five (5) years, and has forty (40) quarters of countable work; or*~~ ~~*(4-1-03)T*~~

0~~*8*~~**7**. **Qualified Non-Citizen Entering On Or After August 22, 1996**. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has had a qualified non-citizen status for at least five (5) years; or (4-1-03)T

0~~*9*~~**8**. **American Indian Born In Canada**. An American Indian born in Canada under 8 U.S.C. 1359; or (4-1-03)T

~~*1*~~0**9**. **American Indian Born Outside The U.S.** An American Indian born outside of the U.S., and is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e); or (4-1-03)T

1~~*1*~~**0**. **Qualified Non-Citizen Child Receiving Federal Foster Care**. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance; or (4-1-03)T

1~~*2*~~**1**. **Victim Of Severe Form Of Trafficking**. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (4-1-03)T

a. Is under the age of eighteen (18) years; or (4-1-03)T

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (4-1-03)T

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (4-1-03)T

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in

persons; or (4-1-03)T

1~~3~~2. Qualified Non-Citizen Receiving Supplement Security Income (SSI). A qualified non-citizen under 8 U.S.C. 1641(b) or (c), and is receiving SSI; or (4-1-03)T

1~~4~~3. Permanent Resident Receiving AABD Cash On August 22, 1996. A permanent resident receiving AABD cash on August 22, 1996. (4-1-03)T

1~~5~~4. Individuals Not Meeting The Citizenship Or Qualified Non-Citizen Requirements. Individuals who do not meet the citizenship or qualified non-citizen requirements in Subsections 106.01 through 106.1~~4~~3 of this rule, may be eligible for emergency medical services if they meet all other conditions of eligibility.
~~*(4-1-03)T*~~(4-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED

DOCKET NO. 16-0305-0301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective April 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-1004(l), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 20, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Section 106 is being amended to clarify and extend eligibility for aid to the aged, blind and disabled to qualified non-citizens in compliance with federal law according to 8 U.S.C. 1641(c).

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with federal regulations.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are being made due to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Maggie Manzo at (208) 334-5753.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before August 27, 2003.

DATED this 23rd day of June, 2003.

Sherri Kovach, Administrative Procedures Coordinator
DHW – Administrative Procedures Section
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Boise, Idaho 83720-0036
(208) 334-5564 phone / (208) 332-7347 fax
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-0301

~~***106. CITIZENSHIP AND LEGAL NON-CITIZEN REQUIREMENT.***~~
~~*Individuals must be U.S. citizens or nationals or qualified legal non-citizens to be eligible. Nationals of American Samoa or Swain's Island are the equivalent of U.S. citizens. Only groups of legal non-citizens listed in Subsections 106.01 through 106.09 may be eligible.* (7-1-99)~~

~~***01. Permanent Residents Admitted Before August 22, 1996****. Participants must be:* (7-1-99)~~

~~***a.*** *For AABD cash, legal non-citizens lawfully admitted for permanent residence and getting AABD on August 22, 1996. For Medicaid, legal non-citizens lawfully admitted for permanent residence.* (7-1-99)~~

~~***b.*** *Legal non-citizens of any age who are blind or disabled under the SSI disability criteria and lawfully admitted for permanent residence.* (7-1-99)~~

~~***c.*** *American Indians born in Canada to whom Section 289 of the INA applies or legal non-citizens who are members of Indian tribes.* (7-1-99)~~

~~***d.*** *Legal non-citizens who started AABD or SSI before January 1, 1979.* (7-1-99)~~

~~***02. Battered Non-Citizen Admitted Before August 22, 1996****. A legal non-citizen admitted to the U.S. before August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A) or 204(a)(1)(B) of the INA, as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA who is:* (7-1-99)~~

~~***a.*** *A veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or* (7-1-99)~~

~~***b.*** *Blind or disabled of any age under the SSI disability criteria and lawfully admitted for permanent residence; or* (7-1-99)~~

~~***c.*** *Lawfully admitted for permanent residence and getting AABD.* (7-1-99)~~

~~***03. Permanent Residents Admitted On Or After August 22, 1996****. A lawful permanent resident admitted on or after August 22, 1996 must:* (10-1-02)T~~

~~***a.*** *Be a veteran honorably discharged for a reason other than alienage or is on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or* (10-1-02)T~~

~~***b.*** *Have lived in the U.S. for at least five (5) years and have forty (40) quarters of work.* (10-1-02)T~~

~~***04. Battered Non-Citizen Admitted On Or After August 22, 1996****. A legal non-citizen admitted to the U.S. on or after August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A) or 204(a)(1)(B) of the INA, or as a non-citizen whose deportation is suspended under Section 244(a)(3) of the INA, who is:* (7-1-99)~~

~~***a.*** *A veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty; or* (7-1-99)~~

~~***b.*** *Who has lived in the U.S. for at least five (5) years.* (7-1-99)~~

~~***05. Refugees****. A refugee admitted under Section 207 of the INA, a Cuban/Haitian entrant as defined in Section 501(e) of the Refugee Assistance Act of 1980, or an Amerasian admitted under Section 584 of Public Law 100-202 and amended by Public Law 100-461 is eligible:* (7-1-99)~~

~~***a.*** *For seven (7) years from the date of entry; or* (7-1-99)~~

~~***b.*** *With no time limit if the refugee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***06.*** ***Asylees****. An asylee admitted under Section 208 of the INA is eligible:* *(7-1-99)*~~

~~***a.*** *For seven (7) years from the date asylee status is assigned; or* *(7-1-99)*~~

~~***b.*** *With no time limit if the asylee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***07.*** ***Deportation Withheld****. An individual whose deportation has been withheld under Section 241(b)(3) or 243(h) of the INA is eligible:* *(7-1-99)*~~

~~***a.*** *For seven (7) years from the date deportation was withheld; or* *(7-1-99)*~~

~~***b.*** *With no time limit if the deportee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***08.*** ***Conditional Entrants****. A conditional entrant admitted under Section 203(a)(7) of the INA who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***09.*** ***Parolees****. A person paroled into the U.S. under Section 212(d)(5) of the INA for a period of at least one (1) year, who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. Armed Forces for other than training or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

106. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible, an individual must be a member of one (1) of the groups listed in Subsections 106.01 through 106.14 of this rule. (4-1-03)T

01. U.S. Citizen. A U.S. Citizen; or (4-1-03)T

02. U.S. National, National Of American Samoa Or Swains Island. A U. S. National, National of American Samoa or Swains Island; or (4-1-03)T

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member; or (4-1-03)T

04. Veteran Of The U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran; or (4-1-03)T

05. Non-Citizen Entering The U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, and is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c); or (4-1-03)T

06. Non-Citizen Entering On Or After August 22, 1996. A non-citizen who entered on or after August 22, 1996, and (4-1-03)T

a. Is a refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from

their date of entry; or (4-1-03)T

b. Is an asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date their asylee status is assigned; or (4-1-03)T

c. Is an individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date their deportation or removal was withheld; or (4-1-03)T

d. Is an Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; or (4-1-03)T

e. Is a Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act, and can be eligible for seven (7) years from their date of entry; or (4-1-03)T

07. Legal Permanent Resident (LPR) Entering On Or After August 22, 1996. A legal permanent resident (LPR) entering the U.S. on or after August 22, 1996, who has been living in the U.S. for five (5) years, and has forty (40) quarters of countable work; or (4-1-03)T

08. Qualified Non-Citizen Entering On Or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has had a qualified non-citizen status for at least five (5) years; or (4-1-03)T

09. American Indian Born In Canada. An American Indian born in Canada under 8 U.S.C. 1359; or (4-1-03)T

10. American Indian Born Outside The U.S. An American Indian born outside of the U.S., and is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e); or (4-1-03)T

11. Qualified Non-Citizen Child Receiving Federal Foster Care. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance; or (4-1-03)T

12. Victim Of Severe Form Of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (4-1-03)T

a. Is under the age of eighteen (18) years; or (4-1-03)T

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (4-1-03)T

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (4-1-03)T

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons; or (4-1-03)T

13. Qualified Non-Citizen Receiving Supplement Security Income (SSI). A qualified non-citizen under 8 U.S.C. 1641(b) or (c), and is receiving SSI; or (4-1-03)T

14. Permanent Resident Receiving AABD Cash On August 22, 1996. A permanent resident receiving AABD cash on August 22, 1996. (4-1-03)T

15. Individuals Not Meeting The Citizenship Or Qualified Non-Citizen Requirements. Individuals who do not meet the citizenship or qualified non-citizen requirements in Subsections 106.01 through 106.14 of this rule, may be eligible for emergency medical services if they meet all other conditions of eligibility. (4-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0302

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is October 1, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section 56-1004(1), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The temporary rule and the pending rule are being amended to address comments received during the public comment period of the proposed rulemaking. Resources are being clarified in Section 200. Section 277 and 436 are being amended to clarify how real estate contracts are considered for income and resources when determining Medicaid eligibility. Section 788 is being amended to clarify age for the aged and disabled waiver. Section 841 is being amended to be clarify an asset transfer penalty exception.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule.

Only the sections that have changes different from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the October Administrative Bulletin, Volume 03-10, pages 243 through 250.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Maggie Manzo at (208) 334-5753.

DATED this 7th day of November, 2003.

Sherri Kovach
Program Supervisor
DHW – Administrative Procedures Section
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IDAPA 16, TITLE 03, CHAPTER 05

RULES GOVERNING AID TO THE AGED, BLIND AND DISABLED (AABD)

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-10, October 1, 2003, pages 243 through 250.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT FOR DOCKET 16-0305-0302

SECTION 200 (Entire Section)

200. RESOURCES DEFINED.
Resources are cash, personal property, real property, and notes receivable ~~*on real property*~~. A participant, or spouse, must have the right, authority, or power to convert the resource to cash. The participant must have the legal right to use the resource for support and maintenance. ~~*(10-1-03)T*~~(10-1-03)T

SECTION 277 (Entire Section)

273. -- 27~~7~~6. (RESERVED).

277. EXCLUDED REAL ESTATE CONTRACT.
The principal balance of a real estate contract is excluded from resources of a participant in long-term care when the Department determines it is in the Department's best interest to exclude the contract. The determination by the Department of its best interest is final. (10-01-03)T

SECTION 436 (Entire Section)

436. REAL ESTATE CONTRACT INCOME.
Payments received on the interest of a negotiable real estate contract are unearned income for Medicaid eligibility. Payments received on the principal of a negotiable real estate contract are a resource for Medicaid eligibility. Payments received on a nonnegotiable real estate contract are unearned income. Principal and interest payments received on an excluded real estate contract of a long-term care participant are unearned income for patient liability. ~~*(10-1-03)T*~~(10-1-03)T

SECTION 788 (Entire Section)

788. AGED AND DISABLED (A&D) WAIVER.

To be eligible, the participant must be disabled or at least eighteen (18) years of age and less than sixty-five (65) years of age and need nursing facility level of care as provided in IDAPA 16.03.09 "Rules Governing the Medical Assistance Program". ~~*(7-1-03)T*~~(10-1-03)T

SUBSECTION 841.10 (Partial Section)

841. PENALTY EXCEPTIONS FOR ASSET TRANSFERS.
A participant is not subject to the asset transfer penalty for taking any action described in Subsections 841.01 through 841.14 of these rules. (10-1-03)T

10. Medicaid Qualification Not The Intent. The participant or spouse proves the assets were transferred exclusively for a purpose other than to qualify for Medicaid or to avoid recovery. ~~*(10-1-03)T*~~(10-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED

DOCKET NO. 16-0305-0302

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 2003 and October 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-1004(l), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

These rules are being amended to clarify the process for applicants to provide Social Security Numbers (SSN) at the time of application. There are new sections being added as well as amending a section for home and community based services and waiver services. These rules are also being amended to clarify asset transfers and resources of income as well as make changes for grammatical and cite references.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code, and are necessary in order to comply with federal regulations.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are being made due to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Maggie Manzo at (208) 334-5753.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 22, 2003.

DATED this 18th day of August, 2003.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
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kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-0302

105. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.
The ~~*participant*~~ applicant must provide his social security number (SSN) or proof he has applied for an SSN, to the Department before approval of eligibility. ~~*The participant*~~ If the applicant has more than one (1) SSN, all numbers must be provided ~~*all SSNs if he has more than one (1)*~~. ~~*AABD must not be denied, delayed, or stopped if the SSN has been applied for, but not issued,*~~ The SSN must be verified by the Social Security Administration (SSA) electronically. ~~*AN SSN is verified when it is provided to the Department by SSA.*~~ An applicant with an unverified SSN is not eligible for AABD cash or Medicaid benefits. The Department must notify the applicant in writing if eligibility is denied or lost for failure to meet the SSN requirement. ~~*(7-1-99)*~~(7-1-03)T

01. Application For SSN. To be eligible the applicant must apply for an SSN, or a duplicate SSN when he cannot provide his SSN to the Department. If the SSN has been applied for but not issued by the SSA, the Department can not deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. (7-1-03)T

02. Failure To Apply For SSN. The applicant may be granted a good cause exception for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: (7-1-03)T

a. Is a member of a recognized religious sect or division of the sect; and (7-1-03)T

b. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number. (7-1-03)T

03. SSN Requirement Waived. An applicant may have the SSN requirement waived when he is: (7-1-03)T

a. Only eligible for emergency medical services as described in Section 801 of these rules; or (7-1-03)T

b. A waived newborn child as described in Section 800 of these rules. (7-1-03)T

(BREAK IN CONTINUITY OF SECTIONS).

200. RESOURCES DEFINED.
Resources are cash, personal property, ~~*and*~~ real property, and notes receivable on real property. A participant, or spouse, must have the right, authority, or power to convert the resource to cash. The participant must have the legal right to use the resource for support and maintenance. ~~*(7-1-99)*~~(10-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

273. -- 27~~6~~7. (RESERVED).

~~***277. EXCLUDED REAL ESTATE CONTRACT.***~~
~~*The principal balance of a real estate contract is excluded from resources of a participant in long-term care. The contract must meet the conditions in Subsections 277.01 through 277.03. The exclusion ends the first month the contract does not produce income. The principal balance is a resource the first moment of the next month. Interest payments on the contract are income for patient liability. This exclusion is not used if it is more restrictive to*~~

~~*Medicaid eligibility than counting the value of the contract.* *(3-15-02)*~~

~~***01. Income Producing**. The contract produces income when payments are made to the participant by the purchaser.* *(4-5-00)*~~

~~***02. Adequate Rate Of Return**. The contract has a rate of return no less than two (2) percentage points below the bank market rate for loans on similar property in the community when the contract was signed.* *(4-5-00)*~~

~~***03. Remainder To Estate**. The remainder of the contract is part of the estate when the participant dies. There are no provisions in the contract having the intent or effect of making the remainder unavailable to Medicaid estate recovery.* *(4-5-00)*~~

(BREAK IN CONTINUITY OF SECTIONS)

436. REAL ESTATE CONTRACT INCOME.
Payments received on the interest of a negotiable real estate contract are unearned income. Payments received on the principal of a negotiable real estate contract are a resource. Payments received on a nonnegotiable real estate contract are unearned income. ~~*Payments received on an excluded real estate contract of a long-term care participant are unearned income.* *(7-1-99)*~~(10-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

721. LONG-TERM CARE RESIDENT AND MEDICAID.
A resident of a long-term care facility must meet the AABD eligibility criteria to be eligible for Medicaid. A long-term care facility is a nursing facility, or an intermediate care facility for the mentally retarded. The need for ~~*L*~~long-term care ~~*certification*~~ is determined using IDAPA 16.03.09, "Rules Governing the Medical Assistance Program~~,~~" ~~*Subsection 160.09*~~. ~~*(7-1-99)*~~(10-1-03)T

01. Resources Of Resident. The resident's resource limit is two thousand dollars ($2,000). Resources of a married person in long-term care are computed using Federal Spousal Impoverishment rules. Under the SSI method, spouses can use the three thousand dollar ($3,000) couple resource limit if more advantageous. The couple must have lived in the nursing home, in the same room, for six (6) months. ~~*The principal balance of an excluded real estate contract is not a resource, unless it is more restrictive to Medicaid eligibility than counting the contract as a resource.* *(7-1-99)*~~(10-1-03)T

02. Medicaid Income Limit Of Long-Term Care Resident Thirty Days Or More. The monthly income limit for a long-term care facility resident is three (3) times the Federal SSI benefit for a single person. To qualify for this income limit the participant must be, or be likely to remain, in long-term care at least thirty (30) consecutive days. ~~*(7-1-99)*~~(10-1-03)T

03. Medicaid Income Limit Of Long-Term Care Resident Less Than Thirty Days. The monthly income limit, for the resident of a long-term care facility for less than thirty (30) consecutive days, is the AABD income limit for the participant's living situation before long-term care. Living situations before long-term care do not include hospital stays. (7-1-99)

04. Income Not Counted. The income listed in Subsections 721.04.a. through 721.04.e. of these rules is not counted to compute Medicaid eligibility for a long-term care facility resident. This income is counted in determining participation in the cost of long-term care. ~~*A VA "Aid and Attendance" allowance and any increment for VA Unusual Medical Expenses is not counted in determining participation in the cost of long-term care, unless the veteran lives in a state operated veterans' home.* *(3-30-01)*~~(10-1-03)T

a. ~~*Excluded AABD income.*~~ Income excluded or disregarded, in determining eligibility for AABD

cash, is not counted. ~~*(7-1-99)*~~(10-1-03)T

b. ~~*RSDI increase.*~~ The September 1972 RSDI increase is not counted. ~~*(7-1-99)*~~(10-1-03)T

c. ~~*VA aid and attendance.*~~ Any VA Aid and Attendance allowance, including any increment which is the result of a VA Unusual Medical Expense allowance, is not counted. These allowances are not counted for patient liability, unless the veteran lives in a state operated veterans' home. ~~*(3-30-01)*~~(10-1-03)T

d. ~~*RSDI COLA increase.*~~ RSDI benefit increases, from cost-of-living adjustments (COLA) after April 1977, are not counted if they made the participant lose SSI or AABD cash. The COLA increases after SSI or AABD cash stopped are not counted. ~~*(7-1-99)*~~(10-1-03)T

e. ~~*Income paid into exempt income trust.*~~ Income paid into an income trust exempt from counting for Medicaid eligibility under Subsection~~*s 701.01 through 701.03*~~ 872.02 of these rules is used for patient liability~~*is not counted*~~. Income paid to the trust and not used for patient liability, is subject to the asset transfer penalty. ~~*(7-1-99)*~~(10-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

787. ~~*PERSON ENTITLED TO*~~ HOME AND COMMUNITY BASED SERVICES (HCBS).
An aged, blind or disabled ~~*person*~~ participant, who is not income eligible for SSI or AABD cash, in his own home~~,~~ ~~*because of income deeming or income limits*~~ or community setting, is eligible for Medicaid if he meets the conditions in Subsections 787.01 through 787.~~*12*~~07 of these rules, and meets all requirements in one (1) of the waiver Sections 788 through 791 of these rules. ~~*(7-1-99)*~~(7-1-03)T

~~***01.*** ***Age****. Is at least eighteen (18) years old.* *(4-5-00)*~~

~~***02.*** ***AABD Criteria****. If under age sixty-five (65), meets the AABD blindness or disability criteria.* *(7-1-99)*~~

0~~*3*~~1. ~~***AABD***~~ **Resource Limit**. Meets the AABD single person resource limit. ~~*(7-1-99)*~~(7-1-03)T

0~~*4*~~2. ~~***HCBS***~~ **Income Limit**. ~~*For the HCBS Aged and Disabled (A&D) waiver, has i*~~Income of the participant must not exceed~~*ing*~~ three (3) times the Federal SSI ~~*benefit payable*~~ monthly ~~*to*~~ benefit for a single person. ~~*For the HCBS Developmentally Disabled (DD) waiver, has income not exceeding three (3) times the Federal SSI benefit payable monthly to a single person.*~~ A married participant living at home with his spouse who is not an HCBS participant, may choose between the SSI, CP, and FSI methods. If his spouse is also an HCBS participant or lives in a nursing home, the couple may choose between the SSI and CP methods. ~~*(3-15-02)*~~(7-1-03)T

~~***05.*** ***Eligible For Long Term Care****. For HCBS-A&D, meets the medical conditions for nursing facility care in accordance with IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Subsection 160.09. For HCBS-DD, meets the medical conditions for ICF/MR care in accordance with IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," Section 143.* *(3-30-01)*~~

0~~*6*~~3. Maintained In The Community. ~~*For HCBS-A&D, can*~~ The applicant must be able to be maintained safely and effectively in his own home or in the community with ~~*A&D waiver services furnished under the Department's HCBS waiver. For HCBS-DD, can be maintained in the community with DD*~~ the waiver services. ~~*(5-3-03)*~~(7-1-03)T

0~~*7*~~4. Cost Of Care. ~~*For HCBS-A&D, can be cared for in the community at a cost not to exceed the statewide average cost of care for the participant's level of care. The estimated cost of care in a nursing facility is the statewide average rate for the level of care the participant requires, charged by the type of facility where he would be placed if he were not living at home. For traumatic brain injury patients, the estimated cost of care is at the nursing facility special rate.*~~ The cost of the participant's care must be determined to be cost effective as provided in IDAPA

16.03.09, "Rules Governing the Medical Assistance Program". ~~(5-3-03)~~(7-1-03)T

0~~8~~5. ~~**Care Requirement**~~ **Waiver Services Needed**. ~~For HCBS-A&D,~~ The participant must ~~require~~ need and receive, or be likely to ~~require~~ need and receive, ~~HCBS-A&D~~ waiver services for thirty (30) consecutive days. ~~For HCBS-DD, must require and receive, or be likely to require and receive, HCBS-DD~~ The participant is ineligible when there is a break in need for, or receipt of, waiver services for thirty (30) consecutive days. ~~(5-3-03)~~(7-1-03)T

0~~9~~6. **Effective Date**. ~~Medicaid is~~ Waiver services are effective the first day ~~of the thirty (30) day period~~ the participant is likely to ~~require~~ need and receive ~~HCBS A&D or HCBS-DD~~ waiver services. ~~The date of the FSI resource assessment is the start date of the first thirty-day (30) period after September 30, 1989, that the participant is likely to require HCBS A&D or HCBS-DD waiver services.~~ Medicaid begins the first day of the month in which the first day of approved waiver services are received. ~~(1-1-03)T~~(7-1-03)T

~~**10.** **Participant With Spouse**. A married participant living at home with his spouse who is not and HCBS participant, can choose between the SSI, CP, and FSI methods. If his spouse is also an HCBS participant or lives in a nursing home, the couple can choose between the SSI and CP methods. (7-1-99)~~

~~**11.** **Continued Services**. The participant must continue to require and receive waiver services. The participant is ineligible when there is a lapse in need for or receipt of waiver services for thirty (30) days. (7-1-99)~~

~~**12**~~**07.** **Annual Limit**. The Department limits the number of participants approved for waiver services each year. A participant who applies for ~~HCBS Medicaid,~~ waiver services after the annual limit ~~on HCBS-A&D or HCBS-DD waiver participants~~ is reached, must be denied ~~Medicaid~~ waiver services. ~~(3-30-01)~~(7-1-03)T

788. AGED AND DISABLED (A&D) WAIVER.
To be eligible the participant must be disabled or at least sixty-five (65) years of age and need nursing facility level of care as provided in IDAPA 16.03.09 "Rules Governing the Medical Assistance Program". (7-1-03)T

789. DEVELOPMENTALLY DISABLED (DD) WAIVER.
To be eligible the participant must be at least eighteen (18) years of age and need the level of care provided by an intermediate care facility for the mentally retarded (ICF/MR) under IDAPA 16.03.09 "Rules Governing the Medical Assistance Program". (7-1-03)T

790. TRAUMATIC BRAIN INJURY (TBI) WAIVER.
To be eligible the participant must have sustained a traumatic brain injury on or after his twenty-second birthday and need nursing facility level of care as provided in IDAPA 16.03.09 "Rules Governing the Medical Assistance Program". (7-1-03)T

791. IDAHO STATE SCHOOL AND HOSPITAL (ISSH) WAIVER.
To be eligible the participant must be at least fifteen (15) years of age but less than nineteen (19) years of age and is currently at or would be placed at the Idaho State School and Hospital (ISSH) if not for waiver services. (7-1-03)T

7~~88~~92. -- 799. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

840. (RESERVED).

841. PENALTY EXCEPTIONS FOR ASSET TRANSFERS.
A participant ~~or spouse who meets a condition~~ is not subject to the asset transfer penalty for taking any action described in Subsections 84~~0~~1.01 through 84~~0~~1.1~~5~~4 ~~is not subject to the asset transfer penalty~~ of these rules.
~~(7-1-99)~~(10-1-03)T

01. Home To Spouse. The asset transferred was a home. Title to the home was transferred to the

spouse. (7-1-99)

02. **Home To Minor Child Or Disabled Adult Child**. The asset transferred was a home. Title to the home was transferred to the child of the participant or spouse. The child must be under age twenty-one (21) or blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. (7-1-99)

03. **Home To Brother Or Sister**. The asset transferred was a home. Title to the home was transferred to a brother or sister of the participant or spouse. The brother or sister must have an equity interest in the transferred home. The brother or sister must reside in that home for at least one (1) year immediately before the month the participant starts long-term care. (7-1-99)

04. **Home To Adult Child**. The asset transferred was a home. Title to the home was transferred to a son or daughter of the participant or spouse, other than a child under the age of twenty-one (21). The son or daughter must reside in that home for at least two (2) years immediately before the month the participant started long-term care. The ~~*son or daughter*~~ adult child must ~~*have*~~ prove he provided nursing facility level medical care to the participant which permitted him to live at home rather than enter long-term care. ~~*(7-1-99)*~~(10-1-03)T

05. **Benefit Of Spouse**. The assets were transferred to the participant's spouse or to another person for the sole benefit of the spouse. (7-1-99)

06. **Transfer From Spouse**. The assets were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. (7-1-99)

07. **Transfer To Child**. The assets were transferred to the participant's child, or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. (7-1-99)

~~***08.*** ***Transfer To Trust For Person Under Age Sixty-Five****. The assets were transferred to a trust for the sole benefit of a person under age sixty-five (65). "Sole benefit" means any remainder in the trust after the person's death must go to his estate, not to another person. The person must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416.* *(7-1-99)*~~

0~~9~~8. **Intent To Get Fair Market Value**. The participant or spouse proves he intended to dispose of the assets at fair market value or for other adequate consideration. (7-1-99)

~~1~~09. **Assets Returned**. All assets transferred for less than fair market value have been returned to the participant. (7-1-99)

1~~1~~0. ~~***No***~~ **Medicaid** ~~***Purpose***~~ **Qualification Not The Intent**. The participant or spouse proves the assets were transferred exclusively for a purpose other than to qualify for Medicaid. ~~*(7-1-99)*~~(10-1-03)T

1~~2~~1. **Undue Hardship**. Denying eligibility would cause an undue hardship. Undue hardship exists if any of the conditions in Subsections 84~~0~~1.1~~2~~1.a. through 84~~0~~1.1~~2~~1.c. of these rules apply. ~~*(4-5-00)*~~(10-1-03)T

a. The participant proves he is not able to pay for his nursing facility services or his ~~*HCBS*~~ wavier services by any ~~*other way. He*~~ means and assigns his rights to recover the asset to the state of Idaho. ~~*(7-1-99)*~~(10-1-03)T

b. The participant proves he did not knowingly transfer the asset~~*. He*~~ and assigns his rights to recover the asset to the state of Idaho. ~~*(7-1-99)*~~(10-1-03)T

c. The ~~*HCBS*~~ waiver participant proves he would be deprived of food, clothing or shelter if all income transferred to the trust is used only for ~~*HCBS*~~ waiver costs~~*. He*~~ and assigns his rights to recover the asset to the state of Idaho. If the participant proves undue hardship, the income paid to meet his needs for food, clothing or shelter is exempt from the asset transfer penalty. It does not invalidate the trust. It is not income for eligibility. ~~*(7-1-99)*~~(10-1-03)T

1~~3~~2. **Exception To Fair Market Value**. The amount received is adequate, even if not fair market value. This exception must meet one (1) of the conditions in Subsections ~~*690.13.a.*~~ 841.12.a. through ~~*690.13.c.*~~ 841.12.c. of these rules. ~~*(7-1-99)*~~(10-1-03)T

a. A forced sale was done under reasonable circumstances. (7-1-99)

b. Little or no market demand exists for the type of asset transferred. (7-1-99)

c. The asset was transferred to settle a legal debt approximately equal to the fair market value of the transferred asset. (7-1-99)

1~~4~~3. **No Benefit To Participant**. The participant received no benefit from the asset. This exception must meet one (1) of the conditions in Subsections ~~*690.14.a. through 690.14.b.*~~ 841.13.a. and 841.13.b. of these rules. ~~*(7-1-99)*~~(10-1-03)T

a. The participant or spouse held title to the property only as a trustee for another person. The participant or spouse had no beneficial interest in the property. (7-1-99)

b. The transfer was done to clear title to property. The participant or spouse had no beneficial interest in the property. (7-1-99)

1~~5~~4. **Fraud Victim**. The asset was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the assets or property, or its equivalent in damages~~*. The participant*~~ and must assign recovery rights to the state of Idaho. ~~*(7-1-99)*~~(10-1-03)T

84~~1~~2. -- 870. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

872. EXEMPT TRUSTS.
A trust, created or funded on or after August 11, 1993, is exempt from trust treatment and not subject to the asset transfer penalty if it meets a condition in Subsections 872.01 through 872.03 of these rules. ~~*(7-1-99)*~~(10-1-03)T

01. **Trust For Disabled Person**. To be exempt, a trust for a disabled person must meet all the conditions in Subsections 872.01.a. through 872.01.f. of these rules. ~~*(7-1-99)*~~(10-1-03)T

a. The trust contains the assets of a person under age sixty-five (65). (7-1-99)

b. The person is blind or totally disabled under the Social Security and SSI rules in 20 CFR Part 416. (7-1-99)

c. The trust is established for the person's benefit by his parent, grandparent, legal guardian or a court. (7-1-99)

d. The trust is irrevocable. (7-1-99)

e. The trust is exempt until the person reaches age sixty-five (65)~~*if the trust is not added to or augmented*~~. After the person reaches age sixty-five (65), additions or augmentations are not exempt from trust treatment. ~~*(7-1-99)*~~(10-1-03)T

f. Upon the person's death, the amount not distributed by the trust must first be paid ~~*for*~~ to the state of Idaho, up to the amount Medicaid has paid ~~*in*~~ on the person's behalf~~*by the state of Idaho*~~. ~~*(7-1-99)*~~(10-1-03)T

02. **Income Trust**. To be exempt, an income trust must meet all the conditions in Subsections 87~~0~~2.02.a. through ~~*702.01.g.*~~ 872.02.f. of these rules. ~~*(7-1-99)*~~(10-1-03)T

a. The trust is established for the sole benefit of a person who would be eligible for Medicaid in long-term care, or eligible for HCBS except for excess income. ~~*(7-1-99)*~~(10-1-03)T

b. All the money in the trust comes from the person's pensions, Social Security and other income, including income earned by the trust. Money paid into the trust is not income for Medicaid eligibility the month received. Money paid into the trust is income for patient liability or client participation. (7-1-99)

c. The trust is irrevocable. The trust document may include a clause allowing the trust to be revoked if the participant leaves the nursing facility or HCBS for a reason other than death, and is no longer eligible for Medicaid because of excess income, if Medicaid is reimbursed up to the amount Medicaid has paid on the person's behalf. ~~*(7-1-99)*~~(10-1-03)T

d. The trust only provides payments for patient liability or client participation, unless the payment meets the undue hardship penalty exception. (7-1-99)

e. Income transferred to the trust and not used to compute patient liability or client participation, is subject to the asset transfer penalty, unless the payment meets the undue hardship penalty exception. (7-1-99)

~~***f.*** *The trust may be dissolved without penalty when the participant is no longer a long-term care or HCBS Medicaid participant for a reason other than death.* *(7-1-99)*~~

~~***g.***~~**f.** Upon the person's death, the amount not distributed by the trust must first be paid ~~*for*~~ to the state of Idaho, up to the amount Medicaid has paid ~~*in*~~ on the person's behalf ~~*by the state of Idaho*~~. ~~*(7-1-99)*~~(10-1-03)T

03. **Trust Managed By Non-Profit Association For Disabled Person**. To be exempt, a trust managed by non-profit association for a disabled person must meet all the conditions in Subsections 872.03.a. through 872.03.e. of these rules. ~~*(7-1-99)*~~(10-1-03)T

a. The trust is established and managed by a nonprofit association. The nonprofit association must not be the participant, his parent or his grandparent. (7-1-99)

b. The trust contains the assets of a disabled person. The person must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. (7-1-99)

c. Accounts in the trust are established only for the benefit of disabled persons. An account can be established by the disabled person, his parent, grandparent, legal guardian, or a court. ~~*The trust can pool accounts for investment and management purposes.*~~ A separate account ~~*in the pool*~~ must be maintained for ~~*the participant*~~ each beneficiary of the trust. For purposes of investment and management, the trust may pool the funds in the accounts. ~~*(7-1-99)*~~(10-1-03)T

d. The trust is irrevocable. (7-1-99)

e. Upon the person's death, the amount not distributed by the trust must first be paid ~~*for*~~ to the state of Idaho, up to the amount Medicaid has paid ~~*in*~~ on the person's behalf ~~*by the state of Idaho*~~. ~~*(7-1-99)*~~(10-1-30)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.08 - RULES GOVERNING TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO (TAFI)

DOCKET NO. 16-0308-0301

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is April 1, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section 56-1004(1), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The temporary rule and the pending rule are being amended to address comments that were received during the public comment period of the proposed rulemaking. The Department is deleting the Subsection 131.07 because it may not require legal permanent residents to have forty (40) quarters of work to be eligible for benefits.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes different from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the August 6, 2003 Idaho Administrative Bulletin, Volume 03-8, pages 62 through 65.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Tiffany Kinzler at (208) 334-6540.

DATED this 29th day of September, 2003.

Sherri Kovach
Program Supervisor
DHW – Administrative Procedures Section
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IDAPA 16, TITLE 03, CHAPTER 08

RULES GOVERNING TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO (TAFI)

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-8, August 6, 2003, pages 62 through 65.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET 16-0308-0301

SUBSECTIONS 131.07 and 131.08 (Partial Section)

131. CITIZENSHIP AND QUALIFIED NON-CITIZEN ~~*CRITERIA*~~ REQUIREMENTS.
To be eligible, an individual must be a member of one (1) of the groups listed in Subsections 131.01 through 131.0~~9~~8 of this rule. ~~*(4-1-03)T*~~(4-1-03)T

~~***07. Legal Permanent Resident (LPR) Entering On Or After August 22, 1996****. A legal permanent resident (LPR) entering the U.S. on or after August 22, 1996, who has been living in the U.S. for five (5) years, and has forty (40) quarters of countable work; or*~~ ~~*(4-1-03)T*~~

0~~*8*~~7. Qualified Non-Citizen Entering On Or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has had a qualified non-citizen status for at least five (5) years; or (4-1-03)T

0~~*9*~~8. Victim Of Severe Form Of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (4-1-03)T

a. Is under the age of eighteen (18) years; or (4-1-03)T

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (4-1-03)T

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (4-1-03)T

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (4-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.08 - RULES GOVERNING TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO (TAFI)

DOCKET NO. 16-0308-0301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective April 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-1004(l), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 20, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Section 131 is being deleted and rewritten. Section 131 will clarify and extend eligibility for Temporary Assistance for Families in Idaho for citizens and qualified non-citizens in compliance with federal law according to 8 U.S.C. 1641(c). This section will also clarify individuals not meeting the citizenship or qualified non-citizens when all other conditions are met, may be eligible for medical services.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with federal regulations.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are being made due to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Tiffany Kinzler at (208) 334-6540.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before August 27, 2003.

DATED this 23rd day of June, 2003.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0308-0301

~~***131. CITIZENSHIP AND LEGAL NON-CITIZEN CRITERIA.***~~
~~*Individuals must be citizens of the United States or be qualified legal non-citizens. Nationals of American Samoa or Swain's Island are the equivalent of U.S. citizens. Only the groups of legal non-citizens listed in Subsections 131.01 through 131.09 may be eligible.* *(7-1-99)*~~

~~***01. Permanent Residents Admitted Before August 22, 1996****. A non-citizen lawfully admitted to the United States for permanent residence before August 22, 1996.* *(7-1-99)*~~

~~***02. Permanent Residents Admitted On Or After August 22, 1996****. A lawful permanent resident admitted on or after August 22, 1996:* *(7-1-99)*~~

~~***a.*** *Who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. armed forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty; or* *(7-1-99)*~~

~~***b.*** *Who has lived in the United States for five (5) years and has forty (40) quarters of work.* *(7-1-99)*~~

~~***03. Refugees****. A refugee admitted under Section 207 of the Immigration and Nationality Act, a Cuban/Haitian entrant as defined in Section 501(e) of the Refugee Assistance Act of 1980, or an Amerasian admitted under Section 584 of Public Law 100-202 and amended by Public Law 100-461, is eligible:* *(7-1-99)*~~

~~***a.*** *For five (5) years from their date of entry; or* *(7-1-99)*~~

~~***b.*** *With no time limit if the refugee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. armed forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***04. Asylees****. An asylee admitted under Section 208 of the Immigration and Nationality Act is eligible:* *(7-1-99)*~~

~~***a.*** *For five (5) years from the date asylee status is assigned; or* *(7-1-99)*~~

~~***b.*** *With no time limit if the asylee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. armed forces, or spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***05. Deportation Withheld****. An individual whose deportation has been withheld under Section 241(b)(3) or 243(h) of the Immigration and Nationality Act is eligible:* *(7-1-99)*~~

~~***a.*** *For five (5) years from the date deportation was withheld; or* *(7-1-99)*~~

~~***b.*** *With no time limit if the deportee is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. armed forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***06. Conditional Entrants****. A conditional entrant admitted under Section 203(a)(7) of the Immigration and Nationality Act and who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. armed forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* *(7-1-99)*~~

~~***07. Parolees****. A person paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one (1) year and who is a veteran honorably discharged for a reason other*~~

~~*than alienage or on active duty in the U.S. armed forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* (7-1-99)~~

~~***08.*** ***Battered Non-Citizen Admitted Before August 22, 1996****. A legal non-citizen admitted to the United States before August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A), 204(a)(1)(B), as a non-citizen whose deportation is suspended under Section 244(a)(3) of the Immigration and Nationality Act and is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. armed forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty.* (7-1-99)~~

~~***09.*** ***Battered Non-Citizen Admitted On Or After August 22, 1996****. A legal non-citizen admitted to the United States on or after August 22, 1996, as a battered non-citizen under Section 204(a)(1)(A), 204(a)(1)(B), or as a non-citizen whose deportation is suspended under Section 244(a)(3) of the Immigration and Nationality Act:* (7-1-99)~~

~~***a.*** *Who is a veteran honorably discharged for a reason other than alienage or on active duty in the U.S. armed forces for other than training, or the spouse or unmarried dependent of the veteran or person on active duty; or* (7-1-99)~~

~~***b.*** *Who has lived in the United States for five (5) years.* (7-1-99)~~

131. CITIZENSHIP AND QUALIFIED NON-CITIZEN CRITERIA.
To be eligible, an individual must be a member of one (1) of the groups listed in Subsections 131.01 through 131.09 of this rule. (4-1-03)T

01. U.S. Citizen. A U.S. Citizen; or (4-1-03)T

02. U.S. National, National Of American Samoa Or Swains Island. A U. S. National, National of American Samoa or Swains Island; or (4-1-03)T

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member; or (4-1-03)T

04. Veteran Of The U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran; or (4-1-03)T

05. Non-Citizen Entering The U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, and is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c); or (4-1-03)T

06. Non-Citizen Entering On Or After August 22, 1996. A non-citizen who entered on or after August 22, 1996, and (4-1-03)T

a. Is a refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from their date of entry; or (4-1-03)T

b. Is an asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date their asylee status is assigned; or (4-1-03)T

c. Is an individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date their deportation or removal was withheld; or (4-1-03)T

d. Is an Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be

eligible for seven (7) years from the date of entry; or (4-1-03)T

e. Is a Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act, and can be eligible for seven (7) years from their date of entry; or (4-1-03)T

07. Legal Permanent Resident (LPR) Entering On Or After August 22, 1996. A legal permanent resident (LPR) entering the U.S. on or after August 22, 1996, who has been living in the U.S. for five (5) years, and has forty (40) quarters of countable work; or (4-1-03)T

08. Qualified Non-Citizen Entering On Or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has had a qualified non-citizen status for at least five (5) years; or (4-1-03)T

09. Victim Of Severe Form Of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (4-1-03)T

a. Is under the age of eighteen (18) years; or (4-1-03)T

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (4-1-03)T

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (4-1-03)T

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (4-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.08 - RULES GOVERNING TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO (TAFI)

DOCKET NO. 16-0308-0302

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-1004(1), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the October 1, 2003 Administrative Bulletin, Volume 03-10, pages 251 and 252.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Tiffany Kinzler at (208) 334-6540.

DATED this 7th day of November, 2003.

Sherri Kovach, Program Supervisor
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IDAPA 16, TITLE 03, CHAPTER 08

RULES GOVERNING TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO (TAFI)

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-10, October 1, 2003, pages 251 and 252.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.08 - RULES GOVERNING TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO (TAFI)

DOCKET NO. 16-0308-0302

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-1004(l), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Section 133 is being amended to clarify the Social Security Number (SSN) requirements to align with the federal requirements that the SSN must be verified before an applicant is eligible for TAFI benefits.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with federal regulations.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are being made due to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Tiffany Kinzler at (208) 334-6540.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 22, 2003.

DATED this 8th day of August, 2003.

Sherri Kovach
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0308-0302

133. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.
An applicant must provide his Social Security Number (SSN), or proof ~~*of an application*~~ he has applied for an SSN, ~~*must be provided*~~ to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. The SSN must be verified by the Social Security Administration (SSA) electronically. When an SSN is unverified, the applicant is not eligible for TAFI benefits and makes the family ineligible for TAFI. The Department must notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. ~~*(3-30-01)*~~(7-1-03)T

01. **Application For SSN**. The applicant must apply for an SSN, or a duplicate SSN when he cannot provide his SSN to the Department. If the SSN has been applied for but not issued by the SSA, the Department can not deny, delay or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. (7-1-03)T

02. **Failure To Apply For SSN**. The applicant may be granted good cause for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: (7-1-03)T

a. Is a member of a recognized religious sect or division of the sect; and (7-1-03)T

b. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number. (7-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0212

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b); 56-203(g), (i), (j); 56-1003(l); 56-1004(l)(a), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the December 4, 2002, Idaho Administrative Bulletin, Volume 02-12, pages 69 through 80.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Arla Farmer at (208) 364-1958.

DATED this 21st day of March, 2003.

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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 02-12, December 4, 2002, pages 69 through 80.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0212

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective October 1, 2002.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 56-202(b); 56-203(g), (i), (j); 56-1003(l); 56-1004(l)(a), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 18, 2002.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

The proposed amendments in these rules regarding Traumatic Brain Injury (TBI) will clarify provider qualifications and update terminology to read consistently within the TBI rules and with the other Home and Community Based Services (HCBS) Waivers.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(a) and (c), Idaho Code and are necessary in order protect public health, safety or welfare and to confer a benefit to the public.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, formal negotiated rulemaking was not conducted because input was gathered from stakeholders by other means. However, a statewide waiver improvement group participated in the rule change process and input from statewide brain injury councils, regional staff, and other interested stakeholders was included as well.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Arla Farmer at (208) 364-1958.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before December 25, 2002.

DATED this 15th day of October, 2002.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0212

765. WAIVER SERVICES FOR ADULTS WITH A TRAUMATIC BRAIN INJURY.
Pursuant to 42 CFR Section 435.217, it is the intention of the Department to provide waiver services to eligible ~~*recipients*~~ participants in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to achieve and maintain community integration. For a ~~*recipient*~~ participant to be eligible, the Department must find that the ~~*recipient*~~ participant requires services due to a traumatic brain injury which impairs their mental or physical function or independence, be capable of being maintained safely and effectively in a non-institutional setting and would, in the absence of such services, require the level of care provided in a ~~*NF*~~ nursing facility as set forth in IDAPA 16.03.09, "Rules Governing the Medical Assistance Program," S~~*ubs*~~ection ~~*180.03*~~ 506. ~~*(7-1-99)*~~(10-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

767. DIAGNOSTIC CRITERIA.
In order to qualify for the waiver under this rule the person must have a diagnosis listed in the International Classification of Diseases - Clinical Modification Medicode (ICD-CM). The diagnosis must be within one (1) of the classification codes listed:

TABLE 767

Classification Code Number	Classification Description
348.1	Anoxic brain damage
431	Intra cerebral hemorrhage
800 - 800.9	Fracture of a vault of the skull
801 - 801.99	Fracture of the base of the skull
803 - 803.99	Other skull fractures
804 - 804.99	Multiple fractures involving the skull, face, and other bones
850 - 850.9	Concussion
851 - 851.9	Cerebral laceration and contusion
852 - 852.99	Subarachnoid, subdural, and extradural hemorrhage following injury
853 - 853.99	Other unspecified Intra cerebral hemorrhage following injury
854 - 854.99	Intracranial injury of other and unspecified nature
905 - 907.0	Late effects of skull and face fractures plus late effects of intracranial injury without fractures

~~*(7-1-99)*~~(10-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

769. RESIDENTIAL HABILITATION.
Services consist of an integrated array of individually-tailored services and supports furnished to eligible ~~*recipients*~~ participants designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished are listed in sections 769 through 771 of these rules.
~~*(7-1-99)*~~(10-1-02)T

770. HABILITATION SERVICES.
Services consist of assisting the individual to acquire, retain or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (7-1-99)

01. Self-Direction. Self-direction consists of the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (7-1-99)

02. Money Management. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (7-1-99)

03. Daily Living Skills. Daily living skills consists of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (7-1-99)

04. Socialization. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the ~~*recipient*~~ participant to ~~*their*~~ his community. (Socialization training associated with participation in community activities includes assisting the ~~*recipient*~~ participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the ~~*recipient*~~ participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities which are merely diversional or recreational in nature); ~~*(7-1-99)*~~(10-1-02)T

05. Mobility. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (7-1-99)

06. Behavior Shaping And Management. Behavior shaping and management consists of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (7-1-99)

771. PERSONAL ASSISTANCE SERVICES.
Services consist of assisting the individual in daily living activities, household tasks, and such other routine activities as the ~~*recipient*~~ participant or the ~~*recipient's*~~ participant's primary caregiver(s) are unable to accomplish on his own behalf. ~~*(7-1-99)*~~(10-1-02)T

772. PERSONAL ASSISTANCE SERVICES SKILLS TRAINING.
~~***01. Skills Training.***~~ Skills training consists of teaching waiver ~~*recipients*~~ participants, family members, alternative family caregiver(s), or a ~~*recipient's*~~ participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. ~~*(7-1-99)*~~(10-1-02)T

77~~2~~3. -- 779. (RESERVED).

780. CHORE SERVICES.
Services consist of heavy household maintenance and minor home repairs necessary to maintain the functional use of

the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the ~~*recipient's*~~ participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the ~~*recipient*~~ participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the ~~*recipient*~~ participant. ~~*(7-1-99)*~~(10-1-02)T

781. RESPITE CARE SERVICES.
Services consist of those services provided, on a short term basis, in the home of either the waiver ~~*recipient*~~ participant or respite provider, to relieve the person's family or other primary caregiver(s) from daily stress and care demands. While receiving respite care services, the waiver ~~*recipient*~~ participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to ~~*recipients*~~ participants who reside with non-paid caregivers.
~~*(7-1-99)*~~(10-1-02)T

(BREAK IN CONTINUITY OF SECTIONS)

783. EXCLUSIONS FROM SUPPORTED EMPLOYMENT.

01. Supported Employment Services. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available/funded under the Rehabilitation Act of 1973 as amended, or IDEA~~*; and the waiver participant has been deinstitutionalized from an NF or ICF/MR at some prior period*~~.
~~*(7-1-99)*~~(10-1-02)T

02. Federal Financial Participation (FFP). FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver ~~*recipients*~~ participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program.
~~*(7-1-99)*~~(10-1-02)T

784. TRANSPORTATION SERVICES.
Services consist of services offered in order to enable waiver ~~*recipients*~~ participants to gain access to waiver and other community services and resources required by the ~~*individual support p*~~Plan of Care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services offered under the State plan, defined at 42 CFR 440.170(a), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized.
~~*(7-1-99)*~~(10-1-02)T

785. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS.
Adaptations consist of interior or exterior physical adaptations to the home, required by the waiver ~~*recipient's*~~ participant's support plan, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver ~~*recipient*~~ participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver ~~*recipient*~~ participant, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the ~~*recipient*~~ participant, such as carpeting, roof repair, or central air conditioning. All services shall be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the ~~*recipient*~~ participant or the ~~*recipient's*~~ participant's family when the home is the ~~*recipient's*~~ participant's principal residence. Portable or non-stationary modifications may be made when

such modifications can follow the ~~*recipient*~~ participant to his next place of residence or be returned to the Department. ~~*(7-1-99)*~~(10-1-02)T

786. SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES.
Specialized medical equipment and supplies consist of devices, controls, or appliances, specified in the ~~*Individual Support*~~ Plan of Care which enable ~~*recipients*~~ participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State ~~*p*~~Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State ~~*p*~~Plan and shall exclude those items which are not of direct medical or remedial benefit to the ~~*recipient*~~ participant. All items shall meet applicable standards of manufacture, design and installation. ~~*(7-1-99)*~~(10-1-02)T

787. PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS).
PERS ~~*consist of a system which*~~ may be provided to monitor waiver ~~*recipient*~~ participant safety and~~*/or*~~ provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to ~~*recipients*~~ participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. ~~*(7-1-99)*~~(10-1-02)T

788. HOME DELIVERED MEALS.
Home delivered meals consist of meals designed to promote adequate waiver ~~*recipient*~~ participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to ~~*recipients*~~ participants who rent or own their own home, who are alone for significant parts of the day, and who have no regular caretaker for extended periods of time. ~~*(7-1-99)*~~(10-1-02)T

789. EXTENDED STATE PLAN SERVICES.

01. Extended State Plan Services. Extended ~~*s*~~State ~~*p*~~Plan services under the waiver consist of physical therapy services; occupational therapy services; and speech, hearing and language services. These services are to be available through the waiver when the need for such services exceeds the therapy limitations under the State ~~*p*~~Plan. Under the waiver, therapy services will include: ~~*(7-1-99)*~~(10-1-02)T

a. Services provided in the waiver ~~*recipient's*~~ participant's residence, day rehabilitation site, or supported employment site; ~~*(7-1-99)*~~(10-1-02)T

b. Consultation with other service providers and family members; (7-1-99)

c. Participation on the ~~*recipient's Individual Support*~~ participant's Plan of Care team. ~~*(7-1-99)*~~(10-1-02)T

790. SKILLED NURSING SERVICES.
Services consist of intermittent or continuous oversight and skilled care in a non-congregate setting, which is within the scope of the Nurse Practice Act and as such must be provided by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are ~~*not*~~ appropriate if they are available and more cost effective than a Home Health visit. Nursing services may include but are not limited to the insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material, the maintenance of volume ventilators including associated tracheotomy care, tracheotomy and oral pharyngeal suctioning, maintenance and monitoring of IV fluids and/or nutritional supplements which are to be administered on a continuous or daily basis, injections, blood glucose monitoring, and blood pressure monitoring. ~~*(7-1-99)*~~(10-1-02)T

791. PERSONAL CARE SERVICES.
Services consist of assistance due to a medical condition which impairs physical or mental function and which maintains a ~~*consumer*~~ participant safely and effectively in ~~*their*~~ his own home or residence. Services include but are not limited to bathing, care of the hair, assistance with clothing, basic skin care, bladder and bowel requirements, medication management, food nutrition and diet activities, active treatment training programs, and non-nasogastric gastrostomy tube feedings. ~~*(7-1-99)*~~(10-1-02)T

792. BEHAVIOR CONSULTATION/CRISIS MANAGEMENT.
Behavior consultation/crisis management consist of services which provide direct consultation and clinical evaluation of ~~*recipients*~~ participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a ~~*recipient*~~ participant. These services also provide emergency back-up involving the direct support of the ~~*recipient*~~ participant in crisis. ~~*(7-1-99)*~~(10-1-02)T

793. DAY REHABILITATION.
Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which take place in a non-residential setting, separate from the home or facility in which the ~~*individual*~~ participant resides. Services shall normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in a~~*n individual's*~~ participant's ~~*p*~~Plan of ~~*c*~~Care. Day rehabilitation services shall focus on enabling the ~~*individual*~~ participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the ~~*p*~~Plan of ~~*c*~~Care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. ~~*(7-1-99)*~~(10-1-02)T

794. PLACE OF SERVICE DELIVERY.
Waiver services for ~~*recipients*~~ participants with a traumatic brain injury may be provided in the ~~*recipient's*~~ participant's personal residence, ~~*specialized*~~ certified family home, waiver facilities, day rehabilitation/supported employment program or community. The following living situations are specifically excluded as a personal residence for the purpose of these rules: ~~*(7-1-99)*~~(10-1-02)T

01. Excluded As A Personal Residence. (7-1-99)

a. Licensed Skilled, or Intermediate Care Facilities, Certified Nursing Facility (NF) or hospital; and (7-1-99)

b. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (7-1-99)

c. Licensed Residential ~~*Care*~~ or Assisted Living Facility~~;~~. ~~*and*~~ ~~*(7-1-99)*~~(10-1-02)T

~~***d.***~~ ~~*Adult Foster Homes.*~~ ~~*(7-1-99)*~~

~~***e***~~**02. Additional Service Limitations**. Additional limitations to specific services are listed under that service definition. ~~*(7-1-99)*~~(10-1-02)T

795. SERVICE DELIVERED FOLLOWING A WRITTEN PLAN.
All waiver services must be authorized by the Regional Medicaid ~~*Unit*~~ Services in the ~~*R*~~region where the ~~*recipient*~~ participant will be residing and provided based on a written ~~*Individual Support*~~ Plan ~~*(ISP)*~~ of Care. ~~*(7-1-99)*~~(10-1-02)T

01. Development Of The ~~*IS*~~Plan Of Care. The ~~*IS*~~Plan of Care is developed by the ~~*IS*~~Plan of Care team which includes: ~~*(7-1-99)*~~(10-1-02)T

a. The Waiver ~~*Recipient*~~ Participant. Efforts must be made to maximize the ~~*recipient's*~~ participant's participation on the team by providing him with information and education regarding his rights; and ~~*(7-1-99)*~~(10-1-02)T

b. The Department's administrative case manager~~ *chosen by the recipient*~~; and ~~*(7-1-99)*~~(10-1-02)T

c. The guardian when appropriate; and (7-1-99)

d. May include others identified by the waiver ~~*recipient*~~ participant. ~~*(7-1-99)*~~(10-1-02)T

02. Assessment Process Approved By The Department. The ~~*IS*~~Plan of Care must be based on an

assessment process approved by the Department. ~~*(7-1-99)*~~(10-1-02)T

03. Included In The ~~*IS*~~Plan Of Care. The ~~*IS*~~Plan of Care must include the following: ~~*(7-1-99)*~~(10-1-02)T

a. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; and (7-1-99)

b. Supports and service needs that are to be met by the ~~*recipient's*~~ participant's family, friends and other community services; and ~~*(7-1-99)*~~(10-1-02)T

c. The providers of waiver services when known; and (7-1-99)

d. Documentation that the ~~*recipient*~~ participant has been given a choice between waiver services and institutional placement; and ~~*(7-1-99)*~~(10-1-02)T

e. The signature of the ~~*recipient*~~ participant or his legal representative and the case manager. ~~*(7-1-99)*~~(10-1-02)T

f. The plan must be revised and updated by the ~~*IS*~~Plan of Care team based upon treatment results or a change in the ~~*recipient's*~~ participant's needs~~*, but at least semi-annually*~~. A new plan must be developed and approved annually. ~~*(7-1-99)*~~(10-1-02)T

04. Authorization Of Services. All services reimbursed under the Home and Community Based Waiver for ~~*recipients*~~ participants with a traumatic brain injury must be authorized prior to the payment of services by the Regional Medicaid ~~*Unit*~~ Services. ~~*(7-1-99)*~~(10-1-02)T

05. Service Supervision. The ~~*Individual Support*~~ Plan of Care which includes all waiver services is monitored by the Department's case manager. ~~*(7-1-99)*~~(10-1-02)T

796. PROVIDER QUALIFICATIONS.
All providers of waiver services must have a valid provider agreement/performance contract with the Department. Performance under this agreement/contract will be monitored by the Regional Medicaid ~~*Unit*~~ Services in each region. ~~*(7-1-99)*~~(1-1-02)T

01. Residential Habilitation Service Providers. ~~*Residential Habilitation services must be provided by an agency that is certified as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies".*~~ Providers of residential habilitation services must meet the following requirements~~.~~: ~~*(7-1-99)*~~(10-1-02)T

a. Direct service staff must meet the following minimum qualifications: be at least eighteen (18) years of age; be a high school graduate or have a GED or demonstrate the ability to provide services according to a~~*n Individual Support*~~ Plan of Care; have current CPR and First Aid certifications; be free from communicable diseases; pass a criminal background check (when residential habilitation services are provided in a ~~*specialized*~~ certified family home, all adults living in the home must pass a criminal background check); participate in an orientation program, including the purpose and philosophy of services, service rules, policies and procedures, proper conduct in relating to waiver participants, and handling of confidential and emergency situations that involve the waiver participant, provided by the agency prior to performing services; and have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. ~~*(7-1-99)*~~(10-1-02)T

b. The provider agency will be responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the ~~*recipient*~~ participant. Skill training ~~*must*~~ may be provided by a Program Coordinator, if no agency is available in their geographic area as outlined in Subsection 796.01.c. of this rule, who has demonstrated experience in writing skill training programs. Additional training requirements may also include~~*at a minimum*~~: instructional technology; behavior technology; feeding; communication/sign language; mobility; assistance with medications (training in assistance with

medications must be provided by a licensed nurse); activities of daily living; body mechanics and lifting techniques; housekeeping techniques and maintenance of a clean, safe, and healthy environment. ~~*(7-1-99)*~~(10-1-02)T

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a Program Coordinator who has a valid case management, service coordination, or targeted service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. ~~*(7-1-99)*~~(10-1-02)T

d. When residential habilitation services are provided in the provider's home, the agency must meet the environmental sanitation standards; fire and life safety standards; and building, construction and physical home standards for certification as a~~*n adult foster*~~ certified family home. Non-compliance with the above standards will be cause for termination of the provider's provider agreement/contract. ~~*(7-1-99)*~~(10-1-02)T

02. Chore Service Providers. Providers of chore services must meet the following minimum qualifications: (7-1-99)

a. Be skilled in the type of service to be provided; and (7-1-99)

b. Demonstrate the ability to provide services according to a~~*n individual support p*~~Plan of Care. ~~*(7-1-99)*~~(10-1-02)T

03. Respite Care Service Providers. Providers of respite care services must meet the following minimum qualifications: (7-1-99)

a. Meet the qualifications prescribed for the type of services to be rendered, for instance. Residential Habilitation providers must be an employee of an agency selected by the waiver participant and/or the family or guardian; and (7-1-99)

b. Have received caregiving instructions in the needs of the person who will be provided the service; and (7-1-99)

c. Demonstrate the ability to provide services according to a~~*n individual support p*~~Plan of Care; and ~~*(7-1-99)*~~(10-1-02)T

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; and (7-1-99)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (7-1-99)

f. Be free of communicable diseases~~.~~; and ~~*(7-1-99)*~~(10-1-02)T

g. ~~*Taken*~~ Have successfully completed a ~~*basic and advanced*~~ traumatic brain injury training course approved by the Department. ~~*(7-1-99)*~~(10-1-02)T

04. Supported Employment Service Providers. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a ~~*basic and advanced*~~ traumatic brain injury training course approved by the Department. ~~*(7-1-99)*~~(10-1-02)T

05. Transportation Service Providers Must: (7-1-99)

a. Possess a valid driver's license; and (7-1-99)

b. Possess valid vehicle insurance. (7-1-99)

06. Environmental Modifications Service Providers. Environmental Modifications services must: (7-1-99)

a. Be done under a permit, if required; and (7-1-99)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (7-1-99)

07. Specialized Medical Equipment And Supplies. Specialized Medical Equipment and Supplies purchased under this service must: (7-1-99)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (7-1-99)

b. Be obtained or provided by authorized dealers of the specific product where applicable. For instance, medical supply businesses or organizations that specialize in the design of the equipment. (7-1-99)

08. Personal Emergency Response Systems. Personal Emergency Response Systems must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (7-1-99)

09. Home Delivered Meal Services. Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (7-1-99)

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; and (7-1-99)

b. Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes; and (7-1-99)

c. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; and (7-1-99)

d. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; and (7-1-99)

e. Provide documentation of current driver's license for each driver; and (7-1-99)

f. Must be inspected and licensed as a food establishment by the District Health Department. (7-1-99)

10. Extended State Plan Service Providers. All therapy services, with the exception of physical therapy, must be provided by a provider agency capable of supervising the direct service. Providers of services must meet the provider qualifications listed in the State Plan and have taken a ~~*basic and advanced*~~ traumatic brain injury training course approved by the Department. ~~*(7-1-99)*~~(10-1-02)T

11. Nursing Service Providers. Nursing Service Providers must provide documentation of current Idaho licensure as a RN or LPN in good standing and have taken a ~~*basic and advanced*~~ traumatic brain injury training course approved by the Department. ~~*(7-1-99)*~~(10-1-02)T

12. Behavior Consultation/Crisis Management Service Providers. Behavior Consultation/Crisis Management Providers must meet the following: (7-1-99)

~~***b***~~**a.** ~~*Must h*~~Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; or ~~*(7-1-99)*~~(10-1-02)T

~~e~~**b.** Be a licensed pharmacist; or (7-1-99)

~~a~~**c.** Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (7-1-99)

~~e~~**d.** Take~~n~~ a ~~*basic and advanced*~~ traumatic brain injury training course approved by the Department. ~~(7-1-99)~~(10-1-02)T

~~d~~**e.** Emergency back-up providers must also meet the minimum provider qualifications under Residential Habilitation services. ~~(7-1-99)~~(10-1-02)T

13. Day Rehabilitation Providers. Day Rehabilitation Providers must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a ~~*basic and advanced*~~ traumatic brain injury course approved by the Department. ~~(7-1-99)~~(10-1-02)T

14. Personal Care Service Providers. Personal Care Service providers must meet the requirements outlined in IDAPA 16.03.09, "Rules Governing Medical Assistance," Subsections 146.06.a. through 146.06.h. - PCS Provider Qualifications. Providers ~~*will be required to*~~ must take a ~~*basic and advanced*~~ traumatic brain injury training course approved by the Department. ~~(7-1-99)~~(10-1-02)T

797. ~~*RECIPIENT*~~ PARTICIPANT ELIGIBILITY DETERMINATION.
~~*Waiver eligibility will be determined by the Regional Medicaid Unit. The recipient must be financially eligible for MA*~~ The Regional Medicaid Services determines whether the participant meets the NH level of care required for waiver eligibility. The self reliance specialist determines whether the participant meets the other MA eligibility requirements as described in IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)," Section ~~*634*~~ 787. ~~*The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan.*~~ In addition, waiver ~~*recipients*~~ participants must meet the following requirements~~.~~: ~~(7-1-99)~~(10-1-02)T

01. Requirements For Determining ~~*Recipient*~~ Participant Eligibility. The Regional Medicaid ~~*Unit*~~ Services must determine that: ~~(7-1-99)~~(10-1-02)T

a. The ~~*recipient*~~ participant would qualify for NF level of care as set forth in Section ~~*180*~~ 506 of these rules~~,~~ if the waiver services listed in Section 765 of these rules were not made available; and ~~(7-1-99)~~(10-1-02)T

b. The ~~*recipient*~~ participant could be safely and effectively maintained in the requested/chosen community residence with appropriate waiver services. This determination must: be made by ~~*a team of individuals*~~ the Department's Case Manager, with input from the ~~*IS*~~Plan of Care team; and prior to any denial of services on this basis, be determined by the Department's Case manager that services to correct the concerns of the team are not available. ~~(7-1-99)~~(10-1-02)T

c. The average daily cost of waiver services and other medical services to the ~~*recipient*~~ participant would not exceed the average daily cost to Medicaid of NF care and other medical costs. Individual ~~*recipients*~~ participants whose cost of services exceeds this average may be approved on a case by case basis that assures that the average per capita expenditures under the waiver do not exceed one hundred percent (100%) of the average per capita expenditures for NF care under the State plan that would have been made in that fiscal year had the waiver not been granted. This approval will be made by a team identified by the Administrators of the Divisions of Medicaid and Family and Community Services. ~~(7-1-99)~~(10-1-02)T

d. Following the approval by the Regional Medicaid ~~*Unit*~~ Services for services under the waiver, the ~~*recipient*~~ participants must receive and continue to receive a waiver service as described in these rules. A ~~*recipient*~~ participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. ~~(7-1-99)~~(10-1-02)T

02. Admission To A Nursing Facility. A ~~*recipient*~~ participant who is determined by the Regional

Medicaid ~~*Unit*~~ Services to be eligible for services under the Home and Community Based Services Waiver for adults with a traumatic brain injury may elect to not utilize waiver services but may choose admission to an NF. ~~*(7-1-99)*~~(10-1-02)T

03. Self-Reliance Specialist. The ~~*recipient's*~~ participant's self-reliance specialist will process the application in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)," as if the application was for admission to a NF except that the ~~*eligibility examiner*~~ self reliance specialist will forward potentially eligible applications immediately to the Regional Medicaid ~~*Unit*~~ Services for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. ~~*(7-1-99)*~~(10-1-02)T

04. Redetermination Process. Case Redetermination. (7-1-99)

a. Financial redetermination will be conducted pursuant to ~~*IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families and Children," and*~~ IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)". Medical redetermination will be made at least annually by the Regional Medicaid ~~*Unit*~~ Services, or sooner at the request of the ~~*recipient*~~ participant, the self-reliance specialist, provider agency or physician. The sections cited implement and are in accordance with Idaho's approved state plan with the exception of deeming of income provisions. ~~*(7-1-99)*~~(10-1-02)T

b. The redetermination process will assess the following factors: (7-1-99)

i. The ~~*recipient's*~~ participant's continued need for waiver services; and ~~*(7-1-99)*~~(10-1-02)T

ii. Discharge from the waiver services program. (7-1-99)

798. PROVIDER REIMBURSEMENT.
The following outlines the criteria used in reimbursing providers for waiver services. (7-1-99)

01. Fee For Services. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (7-1-99)

02. Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (7-1-99)

03. Calculation Of Fees. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the ~~*recipient's*~~ participant's home or other service delivery location when the ~~*recipient*~~ participant is not being provided transportation. ~~*(7-1-99)*~~(10-1-02)T

799. PROVIDER RECORDS.
Three (3) types of record information will be maintained on all ~~*recipients*~~ participants receiving waiver services: ~~*(7-1-99)*~~(10-1-02)T

01. Service Provider Information. Direct Service Provider Information which includes written documentation of each visit made or service provided to the ~~*recipient*~~ participant, and will record at a minimum the following information: ~~*(7-1-99)*~~(10-1-02)T

a. Date and time of visit; and (7-1-99)

b. Services provided during the visit; and (7-1-99)

c. A statement of the ~~*recipient's*~~ participant's response to the service, if appropriate to the service provided, including any changes in the ~~*recipient's*~~ participant's condition; and ~~*(7-1-99)*~~(10-1-02)T

d. Length of visit, including time in and time out, if appropriate to the service provided. Unless the ~~*recipient*~~ participant is determined by the Case manager to be unable to do so, the delivery will be verified by the

~~*recipient*~~ participant as evidenced by their signature on the service record. ~~*(7-1-99)*~~(10-1-02)T

e. A copy of the above information will be maintained in the ~~*recipient's*~~ participant's home unless authorized to be kept elsewhere by the Regional Medicaid ~~*Unit*~~ Services. Failure to maintain documentation according to these rules shall result in the recoupment of funds paid for undocumented services. ~~*(7-1-99)*~~(10-1-02)T

02. ~~***Individual Support***~~ **Plan Of Care**. The ~~*individual support p*~~Plan of Care which is initiated by the Regional Medicaid ~~*Unit*~~ Services and developed by the ~~*C*~~case manager and the ~~*IS*~~Plan of Care team must specify which waiver services are required by the ~~*recipient*~~ participant. The plan will contain all elements required by Subsection 143.03 of these rules and a copy of the most current ~~*individual support p*~~Plan of Care will be maintained in the ~~*recipient's*~~ participant's home and will be available to all service providers and the Department. ~~*(7-1-99)*~~(10-1-02)T

03. Verification Of Services Provided. In addition to the ~~*individual support p*~~Plan of Care, at least monthly the case manager will verify in writing~~,~~ that the services provided were consistent with the ~~*individual support p*~~Plan of Care. Any changes in the plan will be documented and include the signature of the case manager and when possible, the ~~*recipient*~~ participant. ~~*(7-1-99)*~~(10-1-02)T

800. PROVIDER RESPONSIBILITY FOR NOTIFICATION.
It is the responsibility of the service provider to notify the case manager when any significant changes in the ~~*recipient's*~~ participant's condition are noted during service delivery. Such notification will be documented in the service record. ~~*(7-1-99)*~~(10-1-02)T

801. RECORDS MAINTENANCE.
In order to provide continuity of services, when a ~~*recipient*~~ participant is transferred among service providers, or when a ~~*recipient*~~ participant changes case managers, all of the foregoing ~~*recipient*~~ participant records will be delivered to and held by the Regional Medicaid ~~*Unit*~~ Services until a replacement service provider or case manager assumes the case. When a ~~*recipient*~~ participant leaves the waiver services program, the records will be retained by the Regional Medicaid ~~*Unit*~~ Services as part of the ~~*recipient's*~~ participant's closed case record. Provider agencies will be responsible to retain their client's records for three (3) years following the date of service. ~~*(7-1-99)*~~(10-1-02)T

802. HOME AND COMMUNITY-BASED WAIVER ~~*RECIPIENT*~~ PARTICIPANT LIMITATIONS.
The number of Medicaid ~~*recipients*~~ participants to receive waiver services under the home and community based waiver for ~~*recipients*~~ participants with a traumatic brain injury will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30 of each new waiver year. The earliest effective date of waiver service delivery for these ~~*recipients*~~ participants will be October 1 of each new waiver year. ~~*(7-1-99)*~~(10-1-02)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0213

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the December 4, 2002, Idaho Administrative Bulletin, Volume 02-12, pages 81 and 82.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Arla Farmer at (208) 364-1958.

DATED this 9th day of January, 2003.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 02-12, December 4, 2002, pages 81 and 82.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0213

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 2002.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 18, 2002.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

A recent state court decision ruled that the state is not required to pay for abortions to save the health of the woman. The court's action upheld the legality of H.B. 309, Sec. 3 (2001), which struck the health of the mother as reason for a DHW-paid abortion. Effective July 1, 2002, only abortions to save the life of the mother or in cases of rape or incest will be covered through Medicaid. In addition, the rules are being changed to require one physician to certify the need for an abortion after the court found the current two-physician requirement to be contrary to federal law.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. Public comment should be addressed to these additions and deletions.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(c), Idaho Code and are necessary in order to comply with deadlines in amendments to governing law.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes were due to a court decision.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Arla Farmer, (208) 364-1958.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before December 25, 2002.

DATED this 4th day of October, 2002.

Sherri Kovach
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0213

095. ABORTION PROCEDURES.

01. Requirements For Funding Abortions Under Title XIX. The Department will fund abortions under Title XIX only under circumstances where the abortion is necessary to save the life of the woman or in cases of rape or incest as determined by the courts or, where no court determination has been made, if reported to a law enforcement agency. ~~*This Subsection is effective retroactively from October 1, 1993.*~~ ~~*(10-1-93)*~~(7-1-02)T

~~***02. Requirements For Funding Abortions Solely With State Funds**. The Department will fund abortions solely out of state general funds only under circumstances where the abortion is determined to be medically necessary to save the health of the woman. The woman applying for services under this subsection shall apply for and be determined by the Department to be otherwise Medicaid eligible. This Subsection is effective retroactively from February 17, 1994.*~~ ~~*(2-17-94)*~~

0~~3~~2. Required Documentation For Payment. The following documentation shall be provided: (10-1-93)

a. In the case of rape or incest: (10-1-93)

i. A copy of the court determination of rape or incest must be provided; or (10-1-93)

ii. Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency. (10-1-93)

iii. Where the rape or incest was not reported to a law enforcement agency, ~~*two (2)*~~ a licensed physician~~s~~ must certify in writing that, in the physician's~~'~~ professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest to a law enforcement agency. The certification must contain the name and address of the woman; or ~~*(10-1-93)*~~(7-1-02)T

iv. Documentation that the woman was under the age of eighteen (18) at the time of sexual intercourse. ~~*This Subsection 095.03.a. is effective retroactively from October 1, 1993.*~~ ~~*(10-1-93)*~~(7-1-02)T

b. In the case where the abortion is necessary to save the life of the wom~~e~~an, ~~*two (2)*~~ a licensed physician~~s~~ must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman. ~~*This Subsection 095.03.b. is effective retroactively from October 1, 1993.*~~ ~~*(10-1-93)*~~(7-1-02)T

~~***c.** In the case where the abortion is determined to be medically necessary to save the health of the woman, two (2) licensed physicians must certify in writing that the abortion is medically necessary to prevent injury or damage to the health of the woman. The certification must contain the name and address of the woman. This Subsection 095.03.c. is effective retroactively from February 17, 1994.*~~ ~~*(2-17-94)*~~

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0214

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is May 20, 2002. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section(s) 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Changes to this rule are based on comments received in the public hearing, testimony presented before the Senate Health and Welfare Committee and negotiations during the 2003 Legislative session.

Section 805 was amended by deleting the reference to when a prescription drug was “medically necessary” and reference was made to the definition of “medically necessary” as cited in IDAPA 16.03.09.003.40.

Subsection 812.03, “Prior Authorization Drugs,” was deleted, renamed “Prior Authorization” and moved to Section 810. The term “less costly” was deleted and the term “therapeutically interchangeable” was defined. Language was added to clarify what resources the Department may use to determine drugs that are therapeutically interchangeable. The list of items contained in a request for authorization was removed and reference is made to the format prescribed by the Department. Text was added to provide for a seventy-two (72) hour emergency supply of a covered outpatient prescription drug and a twenty-four (24) hour response to a request for prior authorization.

Pursuant to Section 67-5228, Idaho Code, transcriptional corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes that are different from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the December 4, 2002, Administrative Bulletin, Volume 02-12, pages 83 through 87.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Leslie Clement at (208) 364-1840.

DATED this 30th day of April, 2003.

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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 02-12, December 4, 2002, pages 83 through 87.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0309-0214

805. PRESCRIPTION DRUGS.
The Department will pay for those prescription drugs not excluded by Section 811 of these rules which are legally obtainable by the order of a licensed prescriber whose licensing allows for the prescribing of legend drugs, ~~*under Idaho law*~~ as defined by Section 54-1705(27), Idaho Code, and which are deemed medically necessary as defined in Subsection 003.40 of this chapter. ~~*A prescription drug is considered medically necessary if it is reasonably calculated to prevent or treat conditions in the client that endanger life, cause pain, or cause functionally significant deformity or malfunction and if there is no other therapeutically interchangeable prescription drug available or suitable for the client requesting the service which is more conservative or substantially less costly; and the prescription drug meets professionally recognized standards of health care and must be substantiated by prescriber's records including evidence of such medical necessity. Those records must be made available to the Department upon request.*~~
~~*(5-20-02)T*~~(5-20-02)T

(BREAK IN CONTINUITY OF SECTIONS)

808.~~—809.~~ (RESERVED).

8~~1~~09. LIMITATIONS ON PAYMENT.
Medicaid payment for prescription drugs will be limited as follows: (5-20-02)T

01. Days' Supply. Medicaid will not cover any days' supply of prescription drugs which exceeds the quantity or dosage allowed by these rules. (5-20-02)T

02. Brand Name Drugs. Medicaid will not pay for a brand name product which is part of the FUL (federal upper limit) or SMAC (state maximum allowable cost) listing when the physician has not specified the brand name drug to be medically necessary. (5-20-02)T

03. Medication For Multiple Persons. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for the person or persons covered by Medicaid. (5-20-02)T

04. No Prior Authorization. Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in Subsection 812.03 in these rules.

(5-20-02)T

05. Limitations To Discourage Waste. Medicaid may conduct drug utilization reviews and impose limitations for clients whose drug utilization exceeds the standard client profile or disease management guidelines determined by the Department. (5-20-02)T

810. PRIOR AUTHORIZATION.

01. Items Requiring Prior Authorization. Pharmaceutical items requiring prior authorization include: (5-20-02)T

a. Amphetamines and related CNS stimulants; (5-20-02)T

b. Growth hormones; (5-20-02)T

c. Retinoids; (5-20-02)T

d. Brand name drugs when an acceptable generic form exists; (5-20-02)T

e. Medication otherwise covered by the Department for which there is a therapeutically interchangeable alternate medication identified by the Department. For purposes of Subsection 810.01, therapeutically interchangeable means a medication that is interchangeable with another medication within the same pharmacologic or therapeutic class and is as effective as the medication for which it is being interchanged. The Department determines, and will make available to providers, which drugs are therapeutically interchangeable using a number of resources that may include: (5-20-02)T

i. Peer-reviewed medical literature; (5-20-02)T

ii. Randomized clinical trials; (5-20-02)T

iii. Drug comparison studies; (5-20-02)T

iv. Pharmacoeconomic studies; (5-20-02)T

v. Outcomes research data; (5-20-02)T

vi. Idaho practice guidelines; and (5-20-02)T

vii. Consultation with practicing physicians, pharmacists, and the Idaho Medicaid Medical Director. 5-20-02)T

f. Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines. (5-20-02)T

g. Lipase inhibitors. (5-20-02)T

h. Medications prescribed outside of the Food and Drug Administration approved indications. (5-20-02)T

i. Medications excluded in Section 811 of these Rules that the Department accepts for other medically approved indications. (5-20-02)T

02. Request For Prior Authorization. The prior authorization procedure is initiated by the prescriber who must submit the request to the Department in the format prescribed by the Department. (5-20-02)T

03. Notice Of Decision. The Department will determine coverage based on this request, and will notify

the client, prescriber, and pharmacy, if known. (5-20-02)T

04. **Emergency Situation**. The Department will provide for the dispensing of at least a seventy two (72) hour supply of a covered outpatient prescription drug in an emergency situation as required in 42 USC 1396r-8(d)(5)(B). (5-20-02)T

05. **Response To Request**. The Department will respond within twenty four (24) hours to a request for prior authorization of a covered outpatient prescription drug as required in 42 USC 1396r-8(d)(5)(A). (5-20-02)T

(BREAK IN CONTINUITY OF SECTIONS)

812. ADDITIONAL COVERED DRUG PRODUCTS.
Additional drug products will be allowed as follows: (4-5-00)

01. **Therapeutic Vitamins**. Therapeutic vitamins may include: (4-5-00)

a. Injectable vitamin B12 (cyanocobalamin and analogues); (4-5-00)

b. Vitamin K and analogues; (4-5-00)

c. Pediatric legend vitamin-fluoride preparations; (4-5-00)

d. Legend prenatal vitamins for pregnant or lactating women; (4-5-00)

e. Legend folic acid; (4-5-00)

f. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and (4-5-00)

g. Legend vitamin D and analogues. (4-5-00)

02. **Prescriptions For Nonlegend Products**. Prescriptions for nonlegend products may include: (4-5-00)

a. Insulin; (4-5-00)

b. Disposable insulin syringes and needles; (4-5-00)

c. Oral iron salts; and (4-5-00)

d. Permethrin. (4-5-00)

~~***03.*** ***Prior Authorization Drugs****. Drug products that are prior authorized:* *(5-20-02)T*~~

~~***a.*** *Medications requiring prior authorization include:* *(4-5-00)*~~

~~*i.* *Amphetamines and related CNS stimulants;* *(4-5-00)*~~

~~*ii.* *Growth hormones;* *(4-5-00)*~~

~~*iii.* *Retinoids.* *(4-5-00)*~~

~~*iv.* *Brand name drugs when an acceptable generic form exists.* *(3-30-01)*~~

~~*v. Medications otherwise covered by the Department for which there is a less costly, therapeutically interchangeable alternate medication covered by the Department.* *(5-20-02)T*~~

~~*vi. Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines.* *(5-20-02)T*~~

~~*vii. Lipase inhibitors.* *(5-20-02)T*~~

~~*viii. Medications prescribed outside of the Food and Drug Administration approved indications.* *(5-20-02)T*~~

~~***b.*** *Some medications excluded in Section 811 may be accepted for other medically approved indications, provided that prior authorization is obtained.* *(4-5-00)*~~

~~***c.*** *The prior authorization procedure is initiated by the prescriber who must submit the dated and signed request to the Department. This request must include:* *(5-20-02)T*~~

~~*i. Recipient name;* *(4-5-00)*~~

~~*ii. Medicaid identification number;* *(4-5-00)*~~

~~*iii. Date of birth;* *(4-5-00)*~~

~~*iv. Diagnosis;* *(4-5-00)*~~

~~*v. Specific drug;* *(4-5-00)*~~

~~*vi. Strength and dosage;* *(4-5-00)*~~

~~*vii. Statement of medical necessity as to why this drug is needed versus other therapies; and* *(4-5-00)*~~

~~*viii. Duration of therapy desired, not to exceed twelve (12) months.* *(4-5-00)*~~

~~***d.*** *The Department will determine coverage based on this request, and will notify the client, prescriber, and pharmacy, if known. Specific details on the prior authorization procedure can be found in the pharmacy guidelines issued by the Department.* *(4-5-00)*~~

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0214

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective May 20, 2002.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 18, 2002.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Changes to the prescription drug rules are being made to allow better management of Medicaid spending and to make it easier for clients and providers to understand the Medicaid prescription drug program.

Medicaid's current prescription drug rules list the specific names of excluded drugs and drugs which must be prior authorized by the Department. The number of new brand name drugs and classes of drugs which continuously become available make it impossible to continue listing each specific drug in rule.

The rules are being written to allow Medicaid to review brand name prescription drugs for medical necessity when there may be a less expensive and therapeutically interchangeable drug which might also be appropriate for the client's medical condition.

Early refill of prescription drugs has been identified as an unnecessary and costly practice which needs to be controlled to reduce unnecessary Medicaid spending. New rules will require, except for medically necessary situations, that 75% of the estimated days supply of prescription medication has been used before Medicaid will pay for a refill.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Sections 67-5226(1)(a) and (b), Idaho Code and are necessary in order to protect public health safety, or welfare and to comply with deadlines in amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted due to the mandatory reduction in Medicaid spending.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Arla Farmer at (208) 364-1958.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before December 25, 2002.

DATED this 11th day of October, 2002.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
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(208) 334-5564 phone, (208) 332-7347 fax
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0214

805. PRESCRIPTION DRUGS.
The Department will pay for those prescription drugs not excluded by Section 811 which are legally obtainable by the order of a licensed prescriber whose licensing allows for the prescribing of legend drugs under Idaho law and which are deemed medically necessary. A prescription drug is considered medically necessary if it is reasonably calculated to prevent or treat conditions in the client that endanger life, cause pain, or cause functionally significant deformity or malfunction and if there is no other therapeutically interchangeable prescription drug available or suitable for the client requesting the service which is more conservative or substantially less costly; and the prescription drug meets professionally recognized standards of health care and must be substantiated by prescriber's records including evidence of such medical necessity. Those records must be made available to the Department upon request.
~~*(4-5-00)*~~(5-20-02)T

(BREAK IN CONTINUITY OF SECTIONS)

810. ~~*FINANCIAL OBLIGATIONS OF RECIPIENTS*~~ LIMITATIONS ON PAYMENT.
~~*Recipients shall be responsible for prescription charges if*~~ Medicaid payment for prescription drugs will be limited as follows:
~~*(4-5-00)*~~(5-20-02)T

01. Day~~'~~s' Supply. ~~*The day's supply obtained exceeds the Department's allowable amount (recipient pays the cost of the additional medication).*~~ Medicaid will not cover any days' supply of prescription drugs which exceeds the quantity or dosage allowed by these rules.
~~*(4-5-00)*~~(5-20-02)T

~~***02. Drugs Not Covered****. The drugs are not covered by the Medicaid Drug Program (recipient pays the entire cost).*~~
~~*(4-5-00)*~~

0~~*3*~~2. Brand Name Drugs. ~~*The recipient will only accept*~~ Medicaid will not pay for a brand name product which is part of the FUL (federal upper limit) or SMAC (state maximum allowable cost) listing ~~*and*~~ when the physician has not specified the brand name drug to be medically necessary ~~*(recipient pays the entire cost)*~~.
~~*(4-5-00)*~~(5-20-02)T

0~~*4*~~3. Medication For Multiple Persons. When the medication dispensed is for more than one (1) person, ~~*and the second person is not covered under Medicaid (recipient pays the cost of the non-covered person's portion)*~~ Medicaid will only pay for the amount prescribed for the person or persons covered by Medicaid.
~~*(4-5-00)*~~(5-20-02)T

0~~*5*~~4. No Prior Authorization. ~~*The*~~ Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in ~~*Section 808 or*~~ Subsection 812.03 in these rules.
~~*(3-1-02)T*~~(5-20-02)T

05. Limitations To Discourage Waste. Medicaid may conduct drug utilization reviews and impose

limitations for clients whose drug utilization exceeds the standard client profile or disease management guidelines determined by the Department. (5-20-02)T

811. EXCLUDED DRUG PRODUCTS.
The following categories and specific products are excluded: (4-5-00)

01. Non-Legend Medications. Non-legend medications unless included in Subsection 812.02. This includes federal legend medications that change to non-legend status as well as their therapeutic equivalents regardless of prescription status. (4-5-00)

02. Legend Drugs. Any legend drugs for which federal financial participation is not available. (4-5-00)

03. Diet Supplements. Diet supplements and weight loss products, except lipase inhibitors when prior authorized as outlined in Subsection 812.03 of these rules. ~~*(4-5-00)*~~(5-20-02)T

04. Amphetamines And Related Products. Amphetamines and related products~~*, except*~~ for cosmetic purposes or weight loss. Amphetamines and related products which are deemed to be medically necessary may be covered if prior authorized as outlined in Subsection 812.03~~*, including, but not limited to:*~~ of these rules. ~~*(4-5-00)*~~(5-20-02)T

~~***a.*** *Benzphetamine;* *(4-5-00)*~~

~~***b.*** *Chlorphentermine;* *(4-5-00)*~~

~~***c.*** *Chlortermine;* *(4-5-00)*~~

~~***d.*** *Diethylpropion;* *(4-5-00)*~~

~~***e.*** *Fenfluramine;* *(4-5-00)*~~

~~***f.*** *Mazindol;* *(4-5-00)*~~

~~***g.*** *Phendimetrazine;* *(4-5-00)*~~

~~***h.*** *Phenmetrazine;* *(4-5-00)*~~

~~***i.*** *Phentermine;* *(4-5-00)*~~

~~***j.*** *Salts and optical isomers of the above; and* *(4-5-00)*~~

~~***k.*** *Combination products containing any of the above drugs.* *(4-5-00)*~~

05. Ovulation/Fertility Drugs. Ovulation stimulants, fertility drugs, and similar products. ~~*including but not limited to:*~~ ~~*(4-5-00)*~~(5-20-02)T

~~***a.*** *Clomiphene Citrate;* *(4-5-00)*~~

~~***b.*** *Menotropins; and* *(4-5-00)*~~

~~***c.*** *Urofollitropin.* *(4-5-00)*~~

06. Impotency Aids. Impotency aids, either as medication or prosthesis. (4-5-00)

07. Nicotine Products. Nicotine chewing gum, sprays, inhalers, transdermal patches and related products. (4-5-00)

08. Medications Utilized For Cosmetic Purposes. Medications utilized for cosmetic purposes or hair growth. Prior authorization may be granted for these medications if the Department finds other medically necessary indications. (4-5-00)

09. Vitamins. Vitamins unless included in Subsection 812.01. (4-5-00)

~~***10. Medications Not Medically Necessary**. Medications not deemed medically necessary by the Department.* *(4-5-00)*~~

812. ADDITIONAL COVERED DRUG PRODUCTS.
Additional drug products will be allowed as follows: (4-5-00)

01. Therapeutic Vitamins. Therapeutic vitamins may include: (4-5-00)

a. Injectable vitamin B12 (cyanocobalamin and analogues); (4-5-00)

b. Vitamin K and analogues; (4-5-00)

c. Pediatric legend vitamin-fluoride preparations; (4-5-00)

d. Legend prenatal vitamins for pregnant or lactating women; (4-5-00)

e. Legend folic acid; (4-5-00)

f. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and (4-5-00)

g. Legend vitamin D and analogues. (4-5-00)

02. Prescriptions For Nonlegend Products. Prescriptions for nonlegend products may include: (4-5-00)

a. Insulin; (4-5-00)

b. Disposable insulin syringes and needles; (4-5-00)

c. Oral iron salts; and (4-5-00)

d. Permethrin. (4-5-00)

03. Prior Authorization Drugs. ~~*Prior authorization for drugs is as follows*~~ Drug products that are prior authorized: ~~*(4-5-00)*~~(5-20-02)T

a. Medications requiring prior authorization include: (4-5-00)

i. Amphetamines and related CNS stimulants; (4-5-00)

ii. Growth hormones; (4-5-00)

iii. Retinoids. (4-5-00)

iv. Brand name drugs when an acceptable generic form exists. (3-30-01)

v. Medications otherwise covered by the Department for which there is a less costly, therapeutically interchangeable alternate medication covered by the Department. (5-20-02)T

vi. Medications prescribed in quantities which exceed the Food and Drug Administration (FDA)

dosage guidelines. (5-20-02)T

vii. Lipase inhibitors. (5-20-02)T

viii. Medications prescribed outside of the Food and Drug Administration approved indications. (5-20-02)T

b. Some medications excluded in Section 811 may be accepted for other medically approved indications, provided that prior authorization is obtained. (4-5-00)

c. The prior authorization procedure is initiated by the prescriber who ~~*shall*~~ must submit the dated and signed request to the Department. This request ~~*shall*~~ must include: ~~*(3-30-01)*~~(5-20-02)T

i. Recipient name; (4-5-00)

ii. Medicaid identification number; (4-5-00)

iii. Date of birth; (4-5-00)

iv. Diagnosis; (4-5-00)

v. Specific drug; (4-5-00)

vi. Strength and dosage; (4-5-00)

vii. Statement of medical necessity as to why this drug is needed versus other therapies; and (4-5-00)

viii. Duration of therapy desired, not to exceed twelve (12) months. (4-5-00)

d. The Department will determine coverage based on this request, and will notify the client, prescriber, and pharmacy, if known. Specific details on the prior authorization procedure can be found in the pharmacy guidelines issued by the Department. (4-5-00)

813. LIMITATION OF QUANTITIES.
Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the client. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: ~~*(4-5-00)*~~(5-20-02)T

01. Doses Of Medication. Up to one hundred (100) doses of medication may be dispensed, not to exceed a one hundred (100) day supply for: (4-5-00)

a. Cardiac glycosides; (4-5-00)

b. Thyroid replacement hormones; (4-5-00)

c. Prenatal vitamins; (4-5-00)

d. Nitroglycerin products - oral or sublingual; (4-5-00)

e. Fluoride and vitamin/fluoride combination products; and (4-5-00)

f. Nonlegend oral iron salts. (4-5-00)

02. Oral Contraceptive Products. Oral contraceptive products may be dispensed in a quantity sufficient for one (1), two (2), or three (3) cycles. (4-5-00)

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0215

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is April 28, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Section(s) 56-202(b); 56-203(g), (i), (j); 56-1003(l); 56-1004(l)(a), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

In response to comments received in hearings, testimony presented before the Department's legislative committees, and negotiation with providers held during the 2003 Legislative Session, the following amendments have been made to the Temporary rule to address the issue of access to crisis case management services:

1. Maintains the cap for ongoing case management services at four (4) hours per month;
2. Identifies crisis case management as a case management service;
3. Allows agencies to provide up to four (4) hours per month of crisis case management without Department authorization;
4. Requires that a recipient meet newly-developed criteria for a "crisis" before a provider may bill for crisis case management services;
5. Establishes that crisis case management services are linking, coordinating, and advocacy services and not provision of direct services such as crisis counseling, transportation, or skills building;
6. Allows the Department or its designee to authorize beyond the four (4) hour crisis limit if a more restrictive set of criteria are met;
7. Changes the interval for one hundred twenty (120) day service plan reviews to one hundred eighty (180) days;
8. Requires providers to document crisis services and to submit written justification to the Department or its designee for any additional crisis case management authorization; and
9. Allows licensed clinical professional counselors without private practice licensure and marriage and family therapists to provide case management services.

Pursuant to Section 67-5228, Idaho Code, transcriptional, and clerical corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes differing from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the December 4, 2002, Administrative Bulletin, Volume 02-12, pages 88 through 104.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Lloyd Forbes at (208) 364-1833.

DATED this 17th day of March, 2003.

Sherri Kovach
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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 02-12, December 4, 2002, pages 88 through 104.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0309-0215

SUBSECTIONS 478.03, 478.04, and 478.05

478. CASE MANAGEMENT SERVICES.
CM services shall be designed to foster independence and be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational and social services in the least restrictive, most appropriate and most cost-effective setting. CM services shall consist of the following core functions: (12-1-02)T

03. Crisis Case Management. Crisis case management services are linking, coordinating and advocacy services provided to assist a recipient with accessing emergency community resources in order to resolve a crisis. Crisis case management services do not include crisis counseling, transportation to emergency service providers, direct skills building services, or encouragement of independence as identified in Subsection 478.05 of these rules. The crisis must be precipitated by an unanticipated event, circumstance, or life situation that places a recipient at risk of: (4-28-03)T

a. Hospitalization; or (4-28-03)T

b. Incarceration; or (4-28-03)T

c. Becoming homeless; or (4-28-03)T

d. Losing employment or major source of income; or (4-28-03)T

e. Physical harm to self or others, including family altercation or psychiatric relapse. (4-28-03)T

0~~3~~4. **Linking/Coordination Of Services**. Through negotiation and referrals, the case manager links the recipient to various providers of services/care and coordinates service delivery. Coordination of service delivery includes activities such as: assuring that needed services have been delivered, consulting with service providers to ascertain whether they are adequate for the needs of the recipient, and consulting with the client to identify the need for changes in a specific service or the need for additional services. The case manager may refer to his own agency for services but may not restrict the recipient's choice of service providers. It may be necessary to mobilize more than one set of resources to make adequate services available. The case manager may be needed to act as an advocate for the recipient. There must be a minimum of one face-to-face contact with the recipient at least every thirty (30) days. (10-22-93)

0~~4~~5. **Case Manager**. The case manager will encourage independence of the recipient by demonstrating to the individual how to best access service delivery systems such as transportation and Meals on Wheels, etc. Such assistance must be directed toward reducing the number of case management hours needed. Such assistance is limited to thirty (30) days per service delivery system. (3-30-01)

SUBSECTION 480.02.c.

480. CM PROVIDER AGENCY QUALIFICATIONS.
Case management provider agencies must meet the following criteria: (8-1-92)

02. Core Elements. Demonstrated capacity in providing all core elements of case management services to the target population including: (3-30-01)

a. Comprehensive assessment; and (8-1-92)

b. Comprehensive service plan development and implementation; and (8-1-92)

c. Crisis case management services which include arranging access to emergency community resources; and (4-28-03)T

~~c~~d. Linking/coordination of services; and (8-1-92)

~~d~~e. Encouragement of independence. (10-22-93)

SUBSECTIONS 481.07 and 481.08

481. PROVIDER QUALIFICATIONS.
All individual CM providers must be employees of an organized provider agency that has a valid CM provider agreement with the Department. The employing entity will supervise individual CM providers and assure that the following qualifications are met for each individual CM provider. A provider must be a(n): (12-1-02)T

07. Licensed Clinical Professional Counselor. Licensed Clinical Professional Counselor~~ – *Private*~~

~~*Practice Licensure*~~; or ~~*(12-1-02)T*~~(4-28-03)T

08. **Licensed Marriage And Family Therapist**. Licensed Marriage and Family Therapist; or (4-28-03)T

0~~8~~9. **Clinician**. Clinician employed by a state agency and who meets the requirements of the Division of Human Resources and the Personnel Commission; or (12-1-02)T

~~09~~10. **Holder Of A Bachelor's Degree In A Human Services Field**. Individual having a B.A. or B.S. in a human services field and at least one (1) year experience with the target population. Individuals without the one (1) year of experience may gain this experience by working for one (1) year under the supervision of a fully-qualified case manager. (12-1-02)T

SUBSECTIONS 483.06, 483.07, and 483.13

483. PAYMENT FOR SERVICES.
When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as CM services, however, the actual provision of the service does not constitute CM. Medicaid will reimburse only for core services (Section 480 of these rules) provided to members of the eligible target group by qualified staff. (12-1-02)T

06. **Services Delivered Prior To Assessment**. The Department will not provide Medicaid reimbursement for on-going non-crisis case management services delivered prior to the completion of the assessments and individual service plan ~~*if an immediate need is documented*~~. ~~*(12-1-02)T*~~(4-28-03)T

07. **Crisis Case Management**. The Department will provide Medicaid reimbursement for crisis case management services identified under Subsection 478.03 of these rules. Crisis case management services may be delivered prior to, or after, the completion of the assessment and individual service plan. Without authorization by the Department or its designee, crisis case management services are limited to a total of four (4) hours per calendar month. The Department or its designee may authorize additional crisis case management services beyond the four (4) hour limit if a recipient still has severe or prolonged crisis case management needs that meet all of the following criteria: (4-28-03)T

a. The service recipient is at imminent risk (within fourteen (14) days) of hospitalization or institutionalization, including jail or nursing home; and (4-28-03)T

b. The service recipient is experiencing symptoms of psychiatric decompensation; and (4-28-03)T

c. The service recipient has already received the maximum number of monthly hours of ongoing case management and crisis case management services; and (4-28-03)T

d. No other crisis assistance services are available to the recipient under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR). (4-28-03)T

0~~7~~8. **Audit Reviews**. Audit reviews will be conducted at least once a calendar year by the Department or its designee. Review findings may be referred to the Department's Surveillance and Utilization Review Section for appropriate action. (12-1-02)T

0~~8~~9. **Recoupment**. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (3-30-01)

~~09~~10. **Information**. The provider will provide the Department with access to all information required to review compliance with these rules. (3-30-01)

1~~0~~1. Group Case Management. The Department will not provide Medicaid reimbursement for case management services provided to a group of recipients. (3-30-01)

1~~1~~2. Case Management In A Facility. Medicaid will reimburse for case management services on the same date a recipient is admitted or discharged from a hospital, nursing facility, or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of service delivery. Services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those included in the responsibilities of the facility. (3-30-01)

1~~2~~3. On-Going Non-Crisis Case Management. On-going non-crisis case management services are limited to a total of four (4) hours per calendar month. ~~*(12-1-02)T*~~(4-28-03)T

SUBSECTIONS 484.06 and 484.07

484. RECORD REQUIREMENTS.
In addition to the development and maintenance of the service plan, the following documentation must be maintained by the provider: (8-1-92)

06. Activity Record. Activity record describing the recipient and the service provided. The activity record must also include the dated signature and credential(s), including professional license(s), of the service provider. ~~*(3-30-01)*~~(4-28-03)T

07. Documentation. Documented review of progress toward each CM service plan goal, and assessment of the recipient's need for CM and other services at least every one hundred ~~*twenty*~~ eighty (1~~2~~80) days. Documentation to support authorization of crisis case management services beyond the monthly limitation must be submitted to the Department or its designee before such authorization may be granted. Documentation to support delivery of crisis case management services must also be maintained in the recipient's agency record and must include: ~~*(3-30-01)*~~(4-28-03)T

a. A description of the crisis including identification of unanticipated event(s) that precipitate the need for crisis case management services; and (4-28-03)T

b. A brief review of case management and other services or supports available to, or already provided to, the recipient to resolve the crisis; and (4-28-03)T

c. A crisis resolution plan; and (4-28-03)T

d. Outcomes of crisis case management service provision. (4-28-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0215

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective December 1, 2002.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s)56-202(b); 56-203(g), (i), (j); 56-1003(l); 56-1004(l)(a), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 18, 2002.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

As a result of the reduction in the Targeted Service Coordination (TSC) reimbursement, rulemaking relaxes the requirements for targeted service coordinators to reflect that coordinators will now have less hours available for providing case management services. Specifically, these rules removes all caseload limit requirements, and removes the requirement for availability of a care coordinator on a twenty-four (24) hour basis. These rules also incorporate changes to make requirements more consistent across the different types of case management.

As a result of the reduction in the ESC (Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Service Coordinator) reimbursement, rulemaking removes all caseload limit requirements, and removes the requirement for availability of a care coordinator on a twenty-four (24) hour basis.

Reduces ongoing Targeted Case Management (TCM) for the mentally ill from unlimited hours to a maximum of four (4) hours per month. Also removes all caseload limit requirements, and removes the requirement for availability of a case manager on a twenty-four (24) hour basis. Crisis assistance will no longer be a required core element of targeted case management. These rules also incorporate changes to make requirements more consistent across the different types of case management.

Reduces hours available for initial evaluation and service planning from eight (8) hours to six (6) hours.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(c), Idaho Code and are necessary in order to comply with deadlines in amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because rulemaking occurred to comply with executive mandate.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Lloyd Forbes at (208) 364-1833.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before December 25, 2002.

DATED this 10th day of October, 2002.

Administrative Procedures Coordinator
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0215

118. TARGETED DEVELOPMENTAL DISABILITIES SERVICE COORDINATION.
The Department will purchase targeted case management, hereafter referred to as Targeted Service Coordination (TSC) for adult Medicaid eligible recipients with developmental disabilities when authorized by the Regional ACCESS Unit and provided by an organized service coordination provider agency who has entered into a written provider agreement/contract with the Department. The Department will only provide Targeted Service Coordination in a geographic area where such service is not available through a private provider who has entered into a provider agreement/contract with the Department. The purpose of these services is to assist eligible individuals to obtain needed health, educational, vocational, residential, and social services. (3-16-95)

01. Eligible Target Group. Only Medicaid eligible adults, eighteen (18) years of age or older, who desire to live, learn, or work in community based settings are eligible. All participants must have a primary diagnosis of Developmental Disability. (3-30-01)

a. The following diagnostic and functional criteria will be applied to determine membership in the target population: (1-7-94)

i. "Developmental Disability" means a chronic disability of a person which appears before the age of twenty-two (22) years of age and: (10-1-94)

(1) Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and (10-1-94)

(2) Results is substantial functional limitations in three (3) or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (10-1-94)

(3) Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned or coordinated. (10-1-94)

b. Eligible individuals may reside in ~~*adult foster care*~~ certified family homes, residential care, semi-independent living, room and board, their own homes, or be homeless. ~~*(1-7-94)*~~(12-1-02)T

c. Eligible individuals may be receiving habilitation, supportive assistance, respite, or other services. (1-7-94)

02. **Service Description**. TSC shall be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational, residential, and social services using the least restrictive and most appropriate procedures and settings. TSC shall consist of the following core functions: (10-1-94)

a. Individual Assessment and Service Planning. Unless specifically excluded by the recipient, an Individual Support Plan (ISP) shall be developed in conjunction with the recipient, service providers, the recipient's family and/or guardian and other individuals selected by the recipient. (3-16-95)

i. The ISP shall replace existing service plans, except when such plans are required by other rules, and be developed from a person centered planning process and include information obtained from evaluations (assessments), consumer interview, observation in community settings, and other pertinent information. (10-1-94)

ii. The plan shall be directed at meeting the individual recipient's needs, primarily by building on, maintaining, and utilizing the recipient's identified strengths and abilities. Services proposed must: be the result of on-going planning; be built around the recipient's wants and needs; encourage the recipient to choose the locality in which he lives and works; be age appropriate; include, whenever possible, two (2) or more options from which the recipient may choose; be aimed at maximizing community participation; be culturally appropriate; be designed to promote and utilize natural and informal community supports, including family, friends, and other non-paid citizens; and be designed with supports and services necessary to succeed in his chosen environment. (1-7-94)

iii. The plan must be completed within ninety (90) days of the selection of the service coordinator, unless documentation of a delay based on consumer need is submitted to the regional ACCESS unit. (5-24-95)

iv. The plan must be written in language that is easily understood by the consumer and his team. (5-24-95)

b. The service coordinator is responsible for writing the plan, and submitting it to the Regional ACCESS Unit for authorization of Medicaid and state general fund eligibility. The service coordinator will be responsible for finding alternative funding/resources for services and supports not deemed eligible for Medicaid or state general fund reimbursement. (10-1-94)

c. Implementation. The service coordinator shall arrange for services necessary to execute the ISP. (10-1-94)

d. Monitoring. The service coordinator shall review, update and monitor the plan continuously to meet the recipient's changing needs. This can occur through phone contact and/or face-face meetings with the participant. Monitoring includes discussing changes, assessing satisfaction with services, evaluating progress and making necessary changes based on the service coordinator's evaluation. ~~*(10-1-94)*~~(12-1-02)T

~~*i. Discuss the status of the ISP with the recipient in at least one face-to-face contact per month. (10-1-94)*~~

~~*ii. Discuss all proposed changes and the options related to those changes with the recipient. (1-7-94)*~~

~~*iii. Maintain regular contact with all service providers active with the recipient, and participate in meetings to facilitate the coordination of services. (1-7-94)*~~

~~*iv. Discuss the recipient's (family or guardian if appropriate) satisfaction with the quantity and quality of services provided; (1-7-94)*~~

~~*v. Maintain documentation in the ISP of the service coordinator's (family member or guardian if appropriate) observations of the recipient engaged in ISP objective-oriented behavior; (10-1-94)*~~

~~*vi. Evaluate progress toward outcomes identified on the ISP. (10-1-94)*~~

~~*vii. Modify, change, terminate or add services based on these evaluations. (1-7-94)*~~

e. Enablement. The service coordinator shall enable the recipient whenever possible. Enablement includes but is not limited to the following: (10-1-94)

i. Providing information in ways that empower the recipient to make an informed decision; (1-7-94)

ii. Assuring that all placements in the service delivery system shall be to services which offer the individual the best available opportunity for personal development, provide an improved quality of life, and are within the least restrictive environment appropriate to the individual. (1-7-94)

iii. Ensure that all residential arrangements are community-based. Such arrangements may include, but are not limited to, the recipient's family's residence, or an independent living arrangement. (1-7-94)

iv. Ensure that providers comply with clients' rights as specified in the Developmental Disabilities Act. (10-1-94)

v. Assure that no one shall be denied TSC solely on the basis of the severity of physical or mental disability. ~~*(10-1-94)*~~(12-1-02)T

vi. If the placement or services which are recommended are not immediately available, continued attempts to try to access the service or placement for the recipient must be documented. (1-7-94)

vii. The service coordinator will foster the independence of the recipient (family or guardian if appropriate) by demonstrating to the individual how best to access service delivery systems. (10-1-94)

03. Targeted Service Coordination Agency Qualifications. Targeted Service Coordination agencies must meet the following criteria: (10-1-94)

a. Demonstrated ability to provide all the core elements listed in Subsection 119.02 of TSC to the target population; and (10-1-94)

~~***b.*** *Provide consumers of the agency, the availability of a care coordinator on a twenty-four (24) hour basis to assist them in obtaining needed services.* *(10-1-94)*~~

~~***c***~~**b.** May contract with individual service coordinators or case management agencies to provide TSC services. (10-1-94)

~~***d***~~**c.** Not provide service coordination to any individual for whom the agency, owners or employees also provide direct services. Agencies must disclose any interest by the owners of the agency or their employees/ contractors in any other agency that provides services to people with developmental disabilities. (10-1-94)

~~***e***~~**d.** The individual or agency employees successfully complete the service coordination certification training specified by the Department; (10-1-94)

~~***f***~~**e.** The individual or agency follows the written procedures for service coordination authorized and adhered to by the Department; (10-1-94)

~~***g***~~**f.** Adheres to the Department's mission and value statements; and (10-1-94)

~~***h***~~**g.** Adheres to the Department's contract requirements, billing, and reimbursement procedures. (10-1-94)

04. TSC Provider Staff Qualifications. All individual service coordinators must be employees or contractors of an organized provider agency that has a valid provider agreement/contract with the Department. The employing entity will supervise the individual service coordinators and assure that the following qualifications are met for each individual service coordinator: (10-1-94)

a. Must be a psychologist, Ph.D., Ed.D., M.A./M.S.; nurse, B.S.N., M.S., Ph.D.; Q.M.R.P.;

Developmental Specialist; M.D.; D.O.; or possess a valid Idaho social work license issued by the Board of Social Work Examiners; and (10-1-94)

b. Must have documentation of at least ~~*eighteen*~~ twelve (1~~8~~2) months, at an average of twenty (20) hours per week, of on-the-job experience providing service to the target population, or be working under the supervision of a fully qualified service coordinator; and ~~*(10-1-94)*~~(12-1-02)T

c. A criminal history check with finger printing shall be obtained; and (10-1-94)

d. Must be supervised by an individual with the authority to oversee the service delivery, and to remove the individual if the recipient's needs are not met; provider agencies will supervise their service coordinators; and (10-1-94)

e. Cannot be the service coordinator for any recipient for whom the service coordinator has individual responsibility for the provision of any other care or treatment; and (10-1-94)

f. ~~*Cannot be responsible for the service coordination of more than fifty (50) individuals when using one or more paraprofessionals to implement the plan. If not using paraprofessionals, the individual service coordinator's caseload shall not exceed thirty-five (35).*~~ At no time will the total caseload of a service coordinator be so large as to violate the purpose of the program or adversely affect the health and welfare of any recipient served by the service coordinator. ~~*A waiver of the caseload limit may be granted by the Regional ACCESS Unit on a case by case basis and must meet the following criteria:*~~ ~~*(5-24-95)*~~(12-1-02)T

~~*i.*~~ ~~*The availability of service coordinators is not sufficient to meet the needs of the service area; or*~~ ~~*(10-1-94)*~~

~~*ii.*~~ ~~*The recipient who has chosen a particular service coordinator who has reached their limit, has just cause to need that particular provider over other available providers; or*~~ ~~*(10-1-94)*~~

~~*iii.*~~ ~~*The individual service coordinator's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of service coordination services) consumers.*~~ ~~*(10-1-94)*~~

~~*iv.*~~ ~~*The request for waiver must include:*~~ ~~*(10-1-94)*~~

~~*(1)*~~ ~~*The time period for which the waiver is requested; and*~~ ~~*(10-1-94)*~~

~~*(2)*~~ ~~*The alternative caseload limit requested; and*~~ ~~*(10-1-94)*~~

~~*(3)*~~ ~~*Documentation that the granting of the waiver would not diminish the effectiveness of the service coordinator's services, violate the purposes of the program, or adversely affect the health and welfare of any of the service coordinator's consumers.*~~ ~~*(10-1-94)*~~

~~*v.*~~ ~~*The Bureaus may impose any conditions, including limiting the duration of a waiver, which they deem necessary to ensure the quality of TSC services provided.*~~ ~~*(10-1-94)*~~

g. Paraprofessionals may be used to assist in the implementation of the ISP. Paraprofessionals must meet the following qualifications: (10-1-94)

i. Must be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); and (1-7-94)

ii. Must be able to read and write at a level commensurate with the general flow of paperwork and forms; and (1-7-94)

iii. Must complete a training program developed by the Division of Family and Community Services and be working under the supervision of a fully qualified service coordination; and (10-1-94)

iv. A criminal background check will be obtained. (10-1-94)

05. Recipient's Choice. The choice of whether or not to receive TSC services will be the eligible recipient's. All recipients who choose TSC services will have free choice of authorized TSC providers, as well as, the providers of medical and other services under the Medicaid Program. (10-1-94)

06. Payment For Services. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as TSC services, however the actual provision of the services does not constitute TSC. Medicaid will only reimburse for core services (Subsection 118.02) provided to members of the eligible target group by qualified staff. (10-1-94)

a. Payment for TSC will not duplicate payment made to public or private entities under other program authorities for the same purpose. (10-1-94)

b. Payment will not be made for TSC services provided to individuals who are inpatients in NFs, ICFs/MRs, or hospitals. (10-1-94)

i. Medicaid will reimburse for TSC on the same date a recipient is admitted or discharged from NF, ICF/MR or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of the service delivery. (10-1-94)

ii. TSC may be provided during the last thirty (30) days of inpatient stay or when the inpatient stay is not expected to last longer than thirty (30) days when not duplicating those services included in the responsibilities of the facility. (10-1-94)

c. Reimbursement for TSC services shall be made ~~*on a fee-for-service basis for service provided as*~~ at rates established by the Department. ~~*(10-1-94)*~~(12-1-02)T

d. The Department will not provide Medicaid reimbursement for on-going TSC services delivered prior to the completion of assessments and ISP. (10-1-94)

e. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and ISP. (10-1-94)

f. Medicaid reimbursement will be provided only for the following TSC services: (10-1-94)

i. Face-to-face contact between the service coordinator and the recipient, the recipient's family members, guardian, service providers, legal representatives, primary caregivers, or other interested persons; (10-1-94)

ii. Telephone contact between the service coordinator and the recipient, the recipient's family, guardian, service providers, legal representatives, primary caregivers, or other interested persons; (10-1-94)

iii. Development, review, revision of the ISP. (10-1-94)

g. The provider will provide the Department with access to all information required to review compliance with these rules. (1-7-94)

h. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (1-7-94)

i. The Department will not provide Medicaid reimbursement for TSC provided to a group of individuals. (10-1-94)

j. The TSC agency must release all pertinent information to direct service providers when written informed consent is obtained from the recipient. (5-24-95)

07. Record Requirements. In addition to the development and maintenance of the ISP, the following documentation must be maintained by the provider: (10-1-94)

a. Name of recipient; (1-7-94)

b. Name of provider agency and person providing the service; (1-7-94)

c. Date, time, and duration of service; (1-7-94)

d. Place of service delivery; (1-7-94)

e. Activity record describing the service(s) provided; (1-7-94)

f. Documented review of progress toward each service plan goal, and assessment of the recipient's need for TSC and other services as the recipient's needs change; (10-1-94)

g. Documentation justifying the provision of crisis assistance to the recipient; and (1-7-94)

h. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of TSC. (10-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

476. TARGETED CASE MANAGEMENT FOR THE MENTALLY ILL.
The Department will purchase case management (CM) services for adult Medicaid recipients with severe disabling mental illness. Services will be provided by an organized provider agency ~~*which*~~ that has entered into a provider agreement with the Department. The purpose of these services is to assist eligible individuals to gain access to needed medical, social, educational, mental health and other services. ~~*(3-30-01)*~~(12-1-02)T

477. ELIGIBLE TARGET GROUP.
Only those individuals who are mentally ill and eighteen (18) years of age or older who are using or ~~*has*~~ have a history of using high-cost medical services associated with exacerbations of mental illness are eligible for CM services. ~~*(3-30-01)*~~(12-1-02)T

01. Diagnostic And Functional Criteria. The following diagnostic and functional criteria will be applied to determine membership in this target population: (3-30-01)

a. Diagnosis: A condition of severe and persistent mental illness determined by a licensed physician or other licensed practitioner of the healing arts within the scope of his practice under state law, and be a diagnosis listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) within one (1) of the following classification codes for: (3-30-01)

i. Schizophrenia and Other Psychotic Disorders; (3-30-01)

ii. Organic mental disorders associated with Axis III physical disorders or conditions, or whose etiology is unknown; (3-30-01)

iii. Mood disorders - bipolar and depressive; (3-30-01)

iv. Schizoid, Schiz~~p~~otypal, Paranoid, and Borderline Personality disorders. ~~*(3-30-01)*~~(12-1-02)T

v. If the only diagnosis is one (1) or more of the following, the person is not included in the target population for CM services: (8-1-92)

(1) Mental retardation; or (8-1-92)

(2) Alcoholism; or (8-1-92)

(3) Drug abuse. (8-1-92)

b. Functional limitations: The psychiatric disorder must be of sufficient severity to cause a disturbance in the role performance or coping skills in at least two (2) of the following areas, on either a continuous (more than once per year) or an intermittent (at least once per year) basis: (8-1-92)

i. Vocational or academic: Is unemployed, unable to work or attend school, is employed in a sheltered setting or supportive work situation, or has markedly limited skills and a poor work history. (8-1-92)

ii. Financial: Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help, or the person is unable to support him or manage his finances without assistance. (8-1-92)

iii. Social/interpersonal: Has difficulty in establishing or maintaining a personal social support system, has become isolated, has no friends or peer group and may have lost or failed to acquire the capacity to pursue recreational or social interests. (8-1-92)

iv. Family: Is unable to carry out usual roles and functions in a family, such as spouse, parent, or child, or faces gross familial disruption or imminent exclusion from the family. (8-1-92)

v. Basic living skills: Requires help in basic living skills, such as hygiene, food preparation, or other activities of daily living, or is gravely disabled and unable to meet daily living requirements. (8-1-92)

vi. Housing: Has lost or is at risk of losing his current residence. (8-1-92)

vii. Community: Exhibits inappropriate social behavior or otherwise causes a public disturbance due to poor judgment, bizarre, or intrusive behavior which results in intervention by law enforcement and/or the judicial system. (8-1-92)

viii. Health: Requires substantial assistance in maintaining physical health or in adhering to medically rigid prescribed treatment regimens, e.g. brittle diabetic. (3-30-01)

02. Recipient's Residence. Recipients may reside in adult foster care, residential care, semi-independent living, room and board or their own homes. (3-30-01)

03. Other Services. Recipients may be receiving homemaker, personal care, home health, respite or other services. (3-30-01)

04. Hospice Services. Recipients who elect hospice services as found in Section 104, or are receiving case management services through another program are excluded from CM services. (3-30-01)

478. CASE MANAGEMENT SERVICES ~~*DESCRIPTIONS*~~.
CM services shall be designed to foster independence and be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational and social services in the least restrictive, most appropriate and most cost-effective setting. CM services shall consist of the following core functions:
~~*(3-30-01)*~~(12-1-02)T

01. Assessment. A CM provider must have the capacity to perform written comprehensive assessments of a person's assets, deficits and needs. Assessment is an interactive process with the maximum feasible involvement of the recipient. Should the assessments reveal that the person does not need CM services, appropriate referrals will be made to meet other needs of the participant. All the following areas must be evaluated and addressed: (3-30-01)

a. Psychiatric history and current mental status: Includes but is not limited to age of onset, childhood

history of physical or sexual abuse, number of hospitalizations, precursors of hospitalizations, symptoms of decompensation that the client manifests, is the client able to identify his symptoms, medication history; substance abuse history, history of mental illness in the family, current mental status observation, any other information that contributes to their current psychiatric status; and (10-22-93)

b. Medical history and current medical status: Includes but is not limited to history of any major non-psychiatric illnesses, surgeries, hospitalizations, dates of last physical, dental, or eye examinations, pertinent family history of medical illness, current health problems/needs, current medications; name of current physician; and (10-22-93)

c. Vocational status: Includes but is not limited to current and past job status, level of satisfaction with the vocation, educational level, military status, strengths and barriers to employment; and (10-22-93)

d. Financial status: Includes but is not limited to adequacy and stability of the client's financial status, what difficulties they perceive with it, what resources may be available, client's ability to manage personal finances; and (10-22-93)

e. Social relationships/support: Includes but is not limited to client's ability to establish/maintain personal support systems or relationships, client's ability to acquire leisure, recreational, or social interests; and (10-22-93)

f. Family status: Includes but is not limited to: client's ability or desire to carry out family roles, client's perception of the support he receives from their family, what role does the family play in the client's mental illness; and (10-22-93)

g. Basic living skills: Includes but is not limited to client's ability to meet their basic living needs, what does the client want to accomplish in this area; and (10-22-93)

h. Housing: Includes but is not limited to: current living situation and level of satisfaction with the arrangement, is present situation appropriate to the client's needs; and (8-1-92)

i. Community/Legal status: Includes but is not limited to legal history with law enforcement, transportation needs, supports the client has in the community, daily living skills necessary for community living. (8-1-92)

02. Service Plan Development And Implementation. Following the assessment(s) and determination of need for CM, a written service plan shall be developed and implemented as a vehicle to address the case management needs of the recipient. To the maximum extent possible, the development of a service plan shall be a collaborative process involving the recipient, his family or other support system, and the CM provider. The written service plan shall be developed within thirty (30) calendar days of when the recipient chooses the agency as his provider and must be signed by a licensed physician or other licensed practitioner of the healing arts within the scope of his practice under State law according to Title 54, Chapter 18, Idaho Code, indicating the services are medically necessary, and must include, at a minimum: ~~*(3-30-01)*~~(12-1-02)T

a. A list of focus problems identified during the assessments; and (8-1-92)

b. Concrete, measurable goals to be achieved, including time frames for achievement; and (8-1-92)

c. Specific plans directed toward the achievement of each one of the goals; and (8-1-92)

d. Documentation of who has been involved in the service planning; the recipient, if possible, must be involved. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided as to why this was not possible. A copy of the plan must be given to the recipient; and (8-1-92)

e. Reference to any formal services arranged, including specific providers where applicable; and (8-1-92)

f. Planned frequency of services initiated. (8-1-92)

~~***03. Crisis Assistance**. Crisis assistance services are those case management activities that are needed in addition to the assessment and ongoing case management hours in emergency situations. These are necessary activities to obtain services needed to ensure the health and/or safety or to prevent hospitalization or incarceration of a recipient. Crisis assistance may be provided prior to or after the completion of the assessments and individual service plan.* *(8-1-92)*~~

0~~4~~3. Linking/Coordination Of Services. Through negotiation and referrals, the case manager links the recipient to various providers of services/care and coordinates service delivery. Coordination of service delivery includes activities such as: assuring that needed services have been delivered, consulting with service providers to ascertain whether they are adequate for the needs of the recipient, and consulting with the client to identify the need for changes in a specific service or the need for additional services. The case manager may refer to his own agency for services but may not restrict the recipient's choice of service providers. It may be necessary to mobilize more than one set of resources to make adequate services available. The case manager may be needed to act as an advocate for the recipient. There must be a minimum of one face-to-face contact with the recipient at least every thirty (30) days. (10-22-93)

0~~5~~4. Case Manager. The case manager will encourage independence of the recipient by demonstrating to the individual how to best access service delivery systems such as transportation and Meals on Wheels, etc. Such assistance must be directed toward reducing the number of case management hours needed. Such assistance is limited to thirty (30) days per service delivery system. (3-30-01)

479. (RESERVED).

480. CM PROVIDER AGENCY QUALIFICATIONS.
Case management provider agencies must meet the following criteria: (8-1-92)

01. Intake/Pre-Screening. Utilization of a standardized intake and prescreening process for determining whether or not Medicaid eligible individuals are included in the target group for case management services. Prescreening must be effective in sorting out who does and who does not need a full assessment of needs for CM. (3-30-01)

02. Core Elements. Demonstrated capacity in providing all core elements of case management services to the target population including: (3-30-01)

a. Comprehensive assessment; and (8-1-92)

b. Comprehensive service plan development and implementation; and (8-1-92)

~~***c.** Crisis assistance; and* *(8-1-92)*~~

~~d~~c. Linking/coordination of services; and (8-1-92)

~~e~~d. Encouragement of independence. (10-22-93)

~~***03. Availability**. Provides clients of the agency the availability of a case manager on a twenty-four (24) hour basis to assist them in obtaining needed services.* *(3-30-01)*~~

481. PROVIDER QUALIFICATIONS.
All individual CM providers must be employees of an organized provider agency that has a valid CM provider agreement with the Department. The employing entity will supervise individual CM providers and assure that the following qualifications are met for each individual CM provider~~:~~. A provider must be a(n): ~~*(3-30-01)*~~(12-1-02)T

01. ~~***Staff Qualifications***~~ **Psychiatrist**. ~~*Must be a*~~ Psychiatrist, M.D., D.O.; or (12-1-02)T

02. Physician. ~~*p*~~Physician, M.D., D.O.; or (12-1-02)T

03. **Licensed Psychologist**. Licensed Psychologist; or (12-1-02)T

04. **Psychologist Extender**. Psychologist Extender who is registered with the Bureau of Occupational Licenses; or (12-1-02)T

05. **Social Worker**. ~~s~~Social worker with a valid Idaho social work license issued by the Board of Social Work Examiners; or (12-1-02)T

06. **Nurse**. ~~n~~Nurse, R.N.; or (12-1-02)T

07. **Licensed Professional Counselor**. Licensed Professional Counselor - Private Practice Licensure; or (12-1-02)T

08. **Clinician**. ~~a c~~Clinician employed by a state agency and who meets the requirements of the Division of Human Resources and the Personnel Commission; or (12-1-02)T

09. **Holder Of A Bachelor's Degree In A Human Services Field**. ~~an i~~Individual having a B.A. ~~/~~ or B.S. in a human services field and at least one (1) year experience with the target population. Individuals without the one (1) year of experience may gain this experience by working for one (1) year under the supervision of a fully-qualified case manager. ~~(3-30-01)~~(12-1-02)T

~~***02.*** ***Caseload****. A total caseload per case manager of no more than twenty (20) individuals. The Bureau may grant a waiver of the caseload limit when requested by the agency. The following criteria must be met to justify a waiver:* *(3-30-01)*~~

~~***a.*** *The availability of case-management providers is not sufficient to meet the needs of the service area.* *(8-1-92)*~~

~~***b.*** *The recipient that has chosen the particular agency or individual case manager that has reached their limit, and has just cause to need that particular agency or manager over other available agencies/managers.* *(7-1-99)*~~

~~***c.*** *The request for waiver must include:* *(8-1-92)*~~

~~*i.* *The time period for which the waiver is requested;* *(8-1-92)*~~

~~*ii.* *The alternative caseload limit requested;* *(8-1-92)*~~

~~*iii.* *Assurances that the granting of the waiver would not diminish the effectiveness of the CM agency, violate the purposes of the program, or adversely affect the recipients' health and welfare.* *(8-1-92)*~~

~~***d.*** *The Bureau may impose any conditions on the granting of the waiver which it deems necessary.* *(8-1-92)*~~

~~***e.*** *The Bureau may limit the duration of a waiver.* *(8-1-92)*~~

(BREAK IN CONTINUITY OF SECTIONS)

483. PAYMENT FOR SERVICES.
When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as CM services, however, the actual provision of the service does not constitute CM. Medicaid will reimburse only for core services (S~~ubs~~ection ~~116.02~~ 480 of these rules) provided to members of the eligible target group by qualified staff. ~~(8-1-92)~~(12-1-02)T

01. **Duplication**. Payment for CM will not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-30-01)

02. **Inpatients**. Payment will not be made for CM services provided to individuals who are inpatients in nursing homes or hospitals. (3-30-01)

03. **Evaluation/Service Plan Development**. Reimbursement for the initial evaluation and individual service plan development shall be paid based on an hourly rate, not to exceed ~~*eight*~~ six (~~*8*~~6) hours. The rate will be established by the ~~*Bureau*~~ Department. ~~*(3-30-01)*~~(12-1-02)T

04. **Case Management**. Reimbursement for on-going case management services shall be ~~*made on an hourly rate for service delivered. The*~~ at a rate ~~*will be*~~ established by the ~~*Bureau*~~ Department. ~~*(3-30-01)*~~(12-1-02)T

05. **Reimbursement**. Medicaid reimbursement shall be provided only for the following case management services: (3-30-01)

a. Face-to-face contact between the case manager and the recipient, no less than every thirty days; (3-30-01)

b. Telephone contact between the case manager and the recipient, the recipient's mental health and other service providers, a recipient's family members, primary caregivers, legal representative, or other interested persons; (8-1-92)

c. Face-to-face contacts between the case manager and the recipient's family members, legal representative, primary caregivers, mental health providers or other service providers, or other interested persons; (8-1-92)

d. Development, review, and revision of the recipient's individual service plan, including the case manager's functional assessment of the recipient. (8-1-92)

06. **Services Delivered Prior To Assessment**. The Department will ~~*not*~~ provide Medicaid reimbursement for on-going case management services delivered prior to the completion of the assessments and individual service plan if an immediate need is documented. ~~*(3-30-01)*~~(12-1-02)T

~~***07.*** ***Crisis Assistance****. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and individual service plan.* *(3-30-01)*~~

0~~*8*~~7. **Audit Reviews**. Audit reviews will be conducted at least once a calendar year by the ~~*Bureau*~~ Department or its designee. Review findings may be referred to the Department's Surveillance and Utilization Review Section for appropriate action. ~~*(3-30-01)*~~(12-1-02)T

0~~*9*~~8. **Recoupment**. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (3-30-01)

~~*1*~~09. **Information**. The provider will provide the Department with access to all information required to review compliance with these rules. (3-30-01)

1~~*1*~~0. **Group Case Management**. The Department will not provide Medicaid reimbursement for case management services provided to a group of recipients. (3-30-01)

1~~*2*~~1. **Case Management In A Facility**. Medicaid will reimburse for case management services on the same date a recipient is admitted or discharged from a hospital, nursing facility, or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of service delivery. Services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those included in the responsibilities of the facility. (3-30-01)

12. **On-Going Case Management**. On-going case management services are limited to a total of four (4) hours per calendar month. (12-1-02)T

484. RECORD REQUIREMENTS.
In addition to the development and maintenance of the service plan, the following documentation must be maintained by the provider: (8-1-92)

01. **Name**. Name of recipient. (3-30-01)

02. **Provider**. Name of the provider agency and person providing the service. (3-30-01)

03. **Diagnosis**. Diagnosis, contained in Subsection 477.01.a. of these rules, documented by a qualified physician or other licensed practitioner of the healing arts within the scope of his practice under state law, prior to assessment. ~~*(3-30-01)*~~(12-1-02)T

04. **Date**. Date, time, and duration of service. (3-30-01)

05. **Place Of Service**. Place of service. (3-30-01)

06. **Activity Record**. Activity record describing the recipient and the service provided. (3-30-01)

07. **Documentation**. Documented review of progress toward each CM service plan goal, and assessment of the recipient's need for CM and other services at least every one hundred twenty (120) days. (3-30-01)

~~***08.*** ***Justification****. Documentation justifying the provision of crisis assistance to the recipient.* *(3-30-01)*~~

0~~9~~8. **Informed Consent**. An informed consent form signed by the recipient or legal guardian clearly explaining the purpose of case management. (3-30-01)

(BREAK IN CONTINUITY OF SECTIONS)

530. EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICE COORDINATION.
The Department will purchase case management services hereafter referred to as Service Coordination (SC) for Medicaid eligible children age birth to twenty-one (21) years of age who meet medical necessity criteria. (10-1-94)

01. **Medical Necessity Criteria**. Medical necessity criteria for SC services under EPSDT are as follows: (10-1-94)

a. Children eligible for SC must meet one of the following diagnostic criteria: (10-1-94)

i. Children who are diagnosed with a physical or mental condition which has a high probability of resulting in developmental delay or disability, or children with developmental delay or disability. Developmentally delayed children are children with or without established conditions who by assessment measurements have fallen significantly behind developmental norms in one or more of the five functional areas which include cognitive development; physical development including vision and hearing; communication; social/emotional development; and adaptive skills. (10-1-94)

ii. Children who have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize disability. Special health care needs may include a wide range of physical, mental, or emotional limitations from birth defects, illnesses, or injuries. (5-24-95)

iii. Children who have been diagnosed with a severe emotional/behavioral disorder under DSM-IV or subsequent revisions or another classification system used by the Department; and expected duration of the condition

is at least one (1) year or more. (5-24-95)

b. Children eligible for SC must have one (1) or more of the following problems associated with their diagnosis: (10-1-94)

i. The condition requires multiple service providers and treatments; or (10-1-94)

ii. The condition has resulted in a level of functioning below age norm in one (1) or more life areas, such as school, family, or community; or (10-1-94)

iii. There is risk of out-of-home placement or the child is returning from an out-of-home placement as a result of the condition; or (10-1-94)

iv. There is imminent danger to the safety or ability to meet basic needs of the child as a result of the condition; or (10-1-94)

v. Further complications may occur as a result of the condition without provision of service coordination services; and (5-24-95)

vi. The family needs a service coordinator to assist them to access medical and other services for the child. (5-24-95)

02. Service Descriptions. SC services shall be delivered by eligible providers to assist the Medicaid child and their family to obtain and coordinate needed health, educational, early intervention, advocacy, and social services identified in an authorized SC plan developed by the Department or their contractor. Services must take place in the least restrictive, most appropriate and most cost effective setting. SC services shall consist of the following core functions: (10-1-94)

a. Coordination/Advocacy, which is the process of facilitating the child's access to the services, evaluations, and resources identified in the service plan. The case manager may advocate on behalf of the child and family for appropriate community resources and coordinate the multiple providers of social and health services defined in the service plan to avoid the duplication of services for the child. (10-1-94)

b. Monitoring, which is the ongoing process of ensuring that the child's service plan is implemented and assessing the child's progress toward meeting the goals outlined in the service plan and the family's satisfaction with the services. Direct in-person contact with the child and the child's family is essential to the monitoring process. (10-1-94)

c. Evaluation, which is the process of determining whether outcomes have been reached on the service plan, the need for additional revised outcomes, the need for a new plan, or if services are no longer needed. Evaluation is accomplished through periodic in-person reassessment of the child, consultation with the child's family, and consultation and updated assessment from other providers. The addition of new services to the plan or increase in the amount of an authorized service on the existing plan must be authorized by the Department prior to implementation. (5-24-95)

d. Crisis Assistance, which are those SC activities that are needed in emergency situations in addition to those identified on the service plan. These are necessary activities to obtain needed services to ensure the health or safety of the child. To the extent possible the plan should include instructions for families to access emergency services in the event of a crisis. If a need for twenty-four (24) hour availability of service coordination is identified, then arrangements will be made and included on the plan. (10-1-94)

e. Encouragement of Independence, which is the demonstration to the child, parents, family, or legal guardian of how to best access service delivery systems. (10-1-94)

03. SC Provider Agency Qualifications. SC provider agencies must have a valid provider agreement with the Department and meet the following criteria: (10-1-94)

a. Demonstrated experience and competency in providing all core elements of service coordination services to children meeting the medical necessity criteria. (5-24-95)

b. Level of knowledge sufficient to assure compliance with regulatory requirements. Adherence to provision of provider agreement for EPSDT service coordination. Provider agreement may include, but is not limited to, requirements for training, quality assurance, and personnel qualifications. (10-1-94)

04. Service Coordination Individual Provider Staff Qualifications. All individual SC providers must be employees of an organized provider agency that has a valid SC provider agreement with the Department. The employing entity will supervise the individual SC providers and assure that the following qualifications are met for each individual SC provider: (10-1-94)

a. Must be a licensed M.D., D.O., social worker, R.N., or have at least a B.A./B.S. in human/health services field; and have at least one (1) year's experience working with children meeting the medical necessity criteria. (5-24-95)

b. Individuals without the one (1) year experience may gain this experience by working for one (1) year under the supervision of an individual who meets the above criteria. (5-24-95)

c. Paraprofessionals, under the supervision of a qualified SC, may be used to assist in the implementation of the service plan. Paraprofessionals must meet the following qualifications: be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); be able to read at a level commensurate with the general flow of paperwork and forms; meet the employment standards and required competencies of the provider agency; and meet the training requirements according to the agency provider agreement. (10-1-94)

d. Pass a criminal history background check. (10-1-94)

e. ~~*The caseload of service coordinators will be limited to fifty (50) when using one (1) or more paraprofessionals to implement the plan. If not using paraprofessionals, the individual service coordinator's caseload shall not exceed thirty-five (35).*~~ At no time will the total caseload of a service coordinator be so large as to violate the purpose of the program or adversely affect the health and welfare of any children served by the service coordinator. ~~*A waiver of the caseload limit may be granted by the Department on a case by case basis and must meet the following criteria:* *(5-24-95)*~~(12-1-02)T

~~*i.* *The availability of service coordinators is not sufficient to meet the needs of the service area; or* *(5-24-95)*~~

~~*ii.* *The recipient's family who has chosen the particular service coordinator who has reached his limit, has just cause to need that particular provider over other available providers; or* *(5-24-95)*~~

~~*iii.* *The individual service coordinator's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of service coordination services) recipients; and* *(5-24-95)*~~

~~*iv.* *The request for waiver must include:* *(5-24-95)*~~

~~*(1)* *The time period for which the waiver is requested; and* *(5-24-95)*~~

~~*(2)* *The alternative caseload limit requested; and* *(5-24-95)*~~

~~*(3)* *Documentation that the granting of the waiver would not diminish the effectiveness of the service coordinator's services, violate the purposes of the program, or adversely affect the health and safety of any of the service coordinator's consumers.* *(5-24-95)*~~

~~*v.* *The Department may impose any conditions, including limiting the duration of a waiver, which they deem necessary to ensure the quality of the service coordination services provided.* *(5-24-95)*~~

05. Recipient's Choice. The eligible child's family, custodian, or legal guardian will be allowed to

choose whether or not they desire to receive SC services. All eligible children and their families who choose to receive SC services will have free choice of qualified SC providers as well as the qualified providers of medical and other services under the Medicaid program. (10-1-94)

06. Payment For Services. When a recipient is enrolled in managed care/Healthy Connections, the referral for assessment and services must be authorized by primary care providers. When an assessment indicates the need for medical, advocacy, psychiatric, social, educational, early intervention or other services, referral or arrangement for such services may be included as SC services; however, the actual provision of the service does not constitute SC. Medicaid will reimburse for SC services only when ordered by a physician/nurse practitioner/ physician assistant and provided by qualified staff of an approved provider agency or their contractor to eligible children who meet the medical necessity criteria. (5-24-95)

a. Payment for SC will not duplicate payment made to public or private entities under other program authorities for the same purpose. (10-1-94)

b. Payment will not be made for SC services provided to children who are inpatients in nursing facilities or hospitals, other than activities performed within the last thirty (30) days of residence which are directed toward discharge and do not duplicate services included in the facility's content of care. (10-1-94)

c. Reimbursement for ongoing SC services shall be paid ~~*on a fee for service basis for service delivered. The rate shall be*~~ at rates established by the Department or its designee. ~~*(4-5-00)*~~(12-1-02)T

d. Medicaid reimbursement shall be provided only for the following SC services: (10-1-94)

i. Face to face contact between the service coordinator and the eligible child, the child's family members, custodian, legal representative, primary care givers, service providers, or other interested groups or persons; (10-1-94)

ii. Telephone contact between the service coordinator and the child, the child's service providers, the child's family members, custodian or legal guardian, primary caregivers, legal representative, or other interested persons. (10-1-94)

e. Except for crisis assistance the Department will not provide Medicaid reimbursement for ongoing SC services delivered prior to development of the plan by the Department. (10-1-94)

f. Audit reviews will be completed by the Department. (10-1-94)

g. Plans must be reviewed, updated as needed and re-authorized by the Department/Contractor at least annually. Documentation of provision of services will be reviewed and progress toward expected outcomes will be evaluated. Documentation of satisfaction with services and supports will be obtained from parents, family and guardians. (10-1-94)

h. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (10-1-94)

i. The Department will not provide Medicaid reimbursement for SC services provided to a group of children at the same time. (10-1-94)

j. Medicaid will reimburse for SC services on the same date a child is admitted to a hospital, nursing facility, or other institutional setting, so long as the child is not yet admitted at the time of the service delivery. (10-1-94)

07. Record Requirements. The following documentation must be maintained by the provider: (10-1-94)

a. Name of eligible child; and (10-1-94)

b. Name of provider agency and person providing the service; and (10-1-94)

c. A copy of the current approved SC plan which includes the expected outcomes and objectives and is signed by the child's parents, custodian or legal guardian, and the authorizing representative of the Department; and (10-1-94)

d. Date, time, and duration of service; and (10-1-94)

e. Place of service; and (10-1-94)

f. Activity record describing the child and the service provided; and (10-1-94)

g. Documented review of progress toward each SC service plan goal; and (10-1-94)

h. Documentation from parents, family, and guardians of their satisfaction with services and supports. (5-24-95)

i. A copy of the signed informed consent. (5-24-95)

08. **Confidentiality**. No personally identifiable information may be released in the absence of written informed consent for release by the child's parent, custodian or legal guardian. (5-24-95)

09. **Informed Consent**. Informed consent must include an explanation of service coordination and the rights and responsibilities of recipient confidentiality assured through existing state laws and rules. (5-24-95)

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0217

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the December 4, 2002, Idaho Administrative Bulletin, Volume 02-12, pages 112 through 127.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Dr. Thomas Young at (208) 334-5747.

DATED this 9th day of January, 2003.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 02-12, December 4, 2002, pages 112 through 127.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09. RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0217

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective April 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 18, 2002.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

At the current time, the Department is allowed to assess a penalty for late submission of a review document to the Quality Improvement Organization (formally called the Peer Review Organization or PRO). The Department cannot currently assess a penalty for the late submission of a review document that the Department's medical staff reviews. This rule change would allow penalties to be assessed when timely review is not obtained from the Department for physician or outpatient procedures. This would ensure that all procedures are submitted in a timely manner for medical necessity review in order to protect the public health and safety.

This rule change replaces the term "Peer Review Organization" with the new term "Quality Improvement Organization". This change was necessary to meet the changes in 42 CFR Chapter I, IV, and V.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(a), Idaho Code and are necessary in order to protect the public health, safety and welfare.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted. The rule change is for the protection of the public welfare. If the rulemaking is not made, inconsistency in imposing penalties between the late submission of a review document will continue. Those late submissions that the Departments medical staff reviews will not be assessed a penalty and no incentive for the provider to submit timely documentation will continue to be a problem.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Dr. Thomas Young at (208) 334-5747.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before December 25, 2002.

DATED this 23rd day of October, 2002.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 03090217

003. DEFINITIONS.
For the purposes of these rules, the following terms will be used, as defined below: (11-10-81)

01. Abortion. The medical procedure necessary for the termination of pregnancy endangering the life of the woman, or the result of rape or incest, or determined to be medically necessary in order to save the health of the woman. This Subsection is effective retroactively from October 1, 1993. (2-17-94)

02. Access Unit (ACCESS). Access to Care Coordination, Evaluation, Services and Supports. A regional multidisciplinary, transdivisional unit that has the responsibility of determining eligibility, authorizing services, and assuring quality for services and supports for individuals with developmental disabilities. (7-1-95)

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

04. Ambulatory Surgical Center (ASC). Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, and which is certified by the U.S. Department of Health and Human Services as an ASC. (7-1-97)

05. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care or IADLs. These services may include, but are not limited to, personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis or other category of disability. (3-30-01)

06. Authorized Provider. A licensed nurse practitioner, clinical nurse specialist, or physician assistant.
(3-30-01)

07. Bill. The itemized cost of all services provided to one (1) participant on a single claim form.
(3-30-01)

08. Buy-In Coverage. The amount the State pays for Part B of Title C XVIII on behalf of the A/R.
(11-10-81)

09. Category I Sanctions. Less severe administrative sanctions, which can be employed concurrently, which neither require notification nor are subject to appeal unless specifically allowed. (11-10-81)

10. Category II Sanctions. Severe administrative sanctions which are appealable as provided for in

IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (7-1-97)

11. **Central Office**. The administrative headquarters for the Idaho Department of Health and Welfare which are located in the State Office Building (State Towers), 450 West State Street, Boise, Idaho 83720. (11-10-81)

12. **Certified Registered Nurse Anesthetist (CRNA)**. A Registered Nurse qualified by advanced training in an accredited program in the specialty of nurse anesthesia to manage the care of the patient during the administration of anesthesia in selected surgical situations. (7-1-97)

13. **Claim**. An itemized bill for services rendered to one (1) participant by a provider submitted on any of the following Department claim forms: (3-30-01)

a. DHW PH 3-80, "Physician Invoice" or such other claim form as may be prescribed by the Department; or (11-10-81)

b. DHW 03-80, "Title XIX Pharmacy Claim"; or (11-10-81)

c. DHW-AD78, "Adjustment Request"; or (11-10-81)

d. DHW OP REV 4-80, "Hospital Out-patient"; or (11-10-81)

e. DHW IP 3-80, "Hospital In-patient"; or (11-10-81)

f. DHW 0137, "Attending Dentist's Statement"; or (11-10-81)

g. DHW NH 3-80, "Nursing Home Statement"; or (11-10-81)

h. HW-0034 "Consent Form" for sterilization procedures. (11-10-81)

14. **Collateral Contacts**. Contacts made with a parent, guardian, or other individual having a primary relationship to the patient by an appropriately qualified treatment professional. The contact must be ordered by a physician, contained in the treatment plan, directed at the medical treatment of the patient, and documented in the progress notes or continuous service record. (10-6-88)

15. **Community Living Home**. A licensed ICF/MR facility of eight (8) beds or less that has converted to a group home to provide residential habilitation services to developmentally disabled waiver recipients. Room and board is not included in the reimbursement rate. (7-1-95)

16. **Contraception**. The provision of drugs or devices to prevent pregnancy. (1-16-80)

17. **Department**. The state of Idaho Department of Health and Welfare (DHW). (11-10-81)

18. **Director**. The Director of the Idaho Department of Health and Welfare. (11-10-81)

19. **Durable Medical Equipment (DME)**. Equipment other than prosthetics or orthotics which can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a MA participant. (3-30-01)

20. **Educational Services**. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not "related services" as listed in Sections 119 and 120 of these rules; and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-30-01)

21. **Eligibility Manuals**. IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families and

Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled". (3-30-01)

22. **Emergency**. Any situation arising in the medical condition of a patient, which, after applying the prevailing medical standards of judgement and practice within the community requires immediate medical intervention. All obstetrical deliveries are considered emergencies. (10-29-92)

23. **Endangerment Of Life**. A condition where, in the opinion of two (2) licensed physicians, a pregnant woman may die or suffer severe and long lasting physical health damage if the fetus is carried to term. (1-16-80)

24. **Health Authority**. An authorized official of any of the seven (7) Idaho District Health Departments or their satellite centers. (1-16-80)

25. **Home Health Services**. Services ordered by a physician and performed by a licensed nurse, registered physical therapist, or home health aide as defined in IDAPA 16.03.07, Subsection 002.11, "Rules for Home Health Agencies". (3-30-01)

26. **In-Patient Hospital Services**. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (11-10-81)

27. **In-State Care**. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (2-5-93)

28. **Inspection Of Care Team (IOCT)**. An interdisciplinary team which provides inspection of care in intermediate care facilities for the mentally retarded approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-30-01)

a. At least one (1) registered nurse; and (7-1-94)

b. One (1) qualified mental retardation professional; and when required, one (1) of the following: (7-1-94)

i. A consultant physician; or (7-1-94)

ii. A consultant social worker; or (7-1-94)

iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (7-1-94)

29. **Instrumental Activities Of Daily Living (IADL)**. Those activities performed in supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-30-01)

30. **Interested Physician**. (11-10-81)

a. A physician who performs a Medicaid funded abortion for a fee; or (11-10-81)

b. A physician who is related by blood or marriage to another physician performing a Medicaid funded abortion. (11-10-81)

31. **Intermediate Care Facility Services**. Those services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. (3-30-01)

32. **Law Enforcement Authority**. An agency recognized by the state of Idaho in enforcement of established state and federal statutes. (11-10-81)

33. **Legal Representative**. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-30-01)

34. **Legend Drug**. A drug that requires by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. (11-10-81)

35. **Licensed Psychologist**. An individual who is licensed to practice psychology under Chapter 23, Title 54, Idaho Code. (10-6-88)

36. **Licensed, Qualified Professionals**. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (11-10-81)

37. **Lock-In Program**. An administrative sanction, required of participant found to have misused the services provided by the Medical Assistance Program, requiring the participant to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-30-01)

38. **Locum Tenens/Reciprocal Billing**. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis not to exceed a period of fourteen (14) continuous days. (3-15-02)

39. **Medical Care Treatment Plan**. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (11-10-81)

40. **Medical Necessity**. A service is medically necessary if: (7-1-98)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the client that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (7-1-98)

b. There is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly. (7-1-98)

c. Medical services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality. Those records shall be made available to the Department upon request. (7-1-98)

41. **Medical Supplies**. Items excluding drugs and biologicals and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (11-1-86)

42. **Morbid Obesity**. The condition of a person who exceeds ideal weight by more than one hundred (100) pounds and who has significant medical complications directly related to weight gain. (7-1-97)

43. **Non-Legend Drug**. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (11-10-81)

44. **Nurse Midwife**. A registered nurse (RN) who is currently licensed to practice in Idaho, who meets applicable standards as found in the Idaho Nurse Practice Act, Rules and Minimum Standards promulgated by the Idaho State Board of Nursing, and who meets one of the following provisions: (11-10-81)

a. Is currently certified as a Nurse Midwife by the American College of Nurse Midwives; or

(11-10-81)

b. Has satisfactorily completed a formal educational program of at least one (1) academic year that: (11-10-81)

i. Prepares a RN to furnish gynecological and obstetrical care to women during pregnancy, delivery and postpartum, and care to normal newborns; (11-10-81)

ii. Upon completion, qualifies a RN to take the certification examination offered by the American College of Nurse Midwives; (11-10-81)

iii. Includes at least four (4) months, in the aggregate, of classroom instruction and a component of supervised clinical practice; and (11-10-81)

iv. Awards a degree, diploma, or certificate to persons who successfully complete the program. (11-10-81)

45. Nurse Practitioner. A registered nurse (RN) who is currently licensed to practice in this State, who meets applicable standards as found in the Idaho Nurse Practice Act, Rules and Minimum Standards promulgated by the Idaho State Board of Nursing, and who meets one (1) of the following provisions: (11-10-81)

a. Is currently certified as a Primary Care Nurse Practitioner by the American Nurses Association or by the National Board of Pediatric Nurse Practitioners and Associates, or by the Nurses Association of the American College of Obstetricians and Gynecologists; or (11-10-81)

b. Has satisfactorily completed a formal one (1) year academic year educational program that: (11-10-81)

i. Prepares a RN to perform an expanded role in the delivery of primary care; (11-10-81)

ii. Includes at least four (4) months, in the aggregate, of classroom instruction and a component of supervised clinical practice; and (11-10-81)

iii. Awards a degree, diploma, or certificate to persons who successfully complete the program. (11-10-81)

46. Nursing Facility (NF). An institution, or distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services for residents. The residents must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. An institution must provide, on a regular basis, health-related care and services to individuals; who because of their mental or physical condition require care and services above the level of room, board, and supervision; which are made available to them only through institutional facilities, not primarily for care and treatment of mental diseases. The institution is licensed in the state of Idaho pursuant to Section 39-1301, Idaho Code and is certified as a nursing facility pursuant to 42 CFR 405.1120 through 405.1136. (7-1-94)

47. Orthotic. Pertaining to or promoting the straightening of a deformed or distorted part. (10-1-91)

48. Orthotic And Prosthetic Professional. An individual certified or registered by the American Board for Certification in Orthotics and/or Prosthetics. (10-1-91)

49. Other Public Education Agency. Charter schools and the Idaho Infant Toddler Program. (3-30-01)

50. Otologist. A licensed physician who specializes in the diagnosis and treatment of hearing disorders and diseases of the ear. (11-10-81)

51. Out-Patient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative

items or services furnished by or under the direction of a physician or dentist to a patient not in need of hospital bed accommodation. (11-10-81)

52. Out-Of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (7-1-97)

53. Oxygen-Related Equipment. Equipment which is utilized or acquired for the routine administration of oxygen in the home. This includes oxygen tanks, regulators, humidification nebulizers, oxygen concentrators, and related equipment. Equipment which is used solely for the administration of medication into the lungs is excluded from this definition. (11-1-86)

54. Participant. An individual who is receiving Medical Assistance. (3-30-01)

55. Patient. The person undergoing treatment or receiving services from a provider. (11-10-81)

56. Personal Assistance Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, is the employer of record and in fact, and may provide fiscal intermediary services. (3-30-01)

57. Personal Assistance Services (PAS). Services that include attendant care and personal care services. (3-30-01)

58. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (10-1-91)

59. Physician's Assistant. A person who is licensed by the Idaho Board of Medicine and who meets at least one (1) of the following provisions: (7-1-97)

a. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or (11-10-81)

b. Has satisfactorily completed a program for preparing physician's assistants that: (11-10-81)

i. Was at least one (1) academic year in length; and (11-10-81)

ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and (11-10-81)

iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. (11-10-81)

60. Plan Of Care. A written description of medical, remedial and/or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-30-01)

61. Premium Or Subscription Charge. The per capita amount paid by the Department for each eligible MA participant enrolled under a contract for the provisions of medical and rehabilitative care and services whether or not such a participant receives care and services during the contract period. (3-30-01)

62. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-30-01)

63. Prosthetic Device. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of his practice as defined by state law to: (10-1-91)

a. Artificially replace a missing portion of the body; or (10-1-91)

b. Prevent or correct physical deformities or malfunctions; or (10-1-91)

c. Support a weak or deformed portion of the body. (10-1-91)

d. Computerized communication devices are not covered under the definition of a prosthetic device. (7-1-99)

64. **Provider**. Any individual, organization or business entity furnishing medical goods or services in compliance with this chapter and who has applied for and received a provider number, pursuant to Section 020, and who has entered into a written provider agreement, pursuant to Section 040. (7-1-97)

65. **Provider Agreement**. An agreement between the provider and the Department, entered into pursuant to Section 040. (12-31-91)

66. **Provider Reimbursement Manual**. IDAPA 16.03.10, "Rules Governing Provider Reimbursement in Idaho". (7-1-97)

67. **Psychology Assistant**. An individual who practices psychology under the supervision of a licensed psychologist when required under Chapter 23, Title 54, Idaho Code, and Section H of the "Rules of the Idaho State Board of Psychologist Examiners". (7-1-94)

68. **Quality Improvement Organization (QIO).** An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid beneficiaries. A QIO is formerly known as a Peer Review Organization (PRO). In 42 CFR Chapters I, IV, and V, a "Quality Improvement Organization (QIO)" is replacing "Peer Review Organization (PRO)". (4-1-03)T

6~~8~~9. **Recreational Therapy (Services)**. Those activities or services 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, training for Special Olympics, and special day parties (birthday, Christmas, etc.). (10-6-88)

~~69~~70. **Regional Nurse Reviewer (RNR)**. A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX long term care for the Department. (7-1-94)

7~~0~~1. **Social Security Act**. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (11-10-81)

7~~1~~2. **Specialized Family Home**. Living situation where a maximum of two (2) waiver participants who do not require a skilled nursing service live with a provider family of residential habilitation services. (3-30-01)

7~~2~~3. **Speech/Language Pathology And Audiology Services**. Diagnostic, screening, preventative, or corrective services provided by a speech pathologist or audiologist, for which a patient is referred by a physician or other practitioner of the healing arts within the scope of his or her practice under state law. Speech, hearing and language services do not include equipment needed by the patient such as communication devices or environmental controls. (7-1-99)

7~~3~~4. **Subluxation**. A partial or incomplete dislocation of the spine. (11-10-81)

7~~4~~5. **Supervision**. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (6-21-90)

7~~5~~6. **Title XVIII**. That program established by the 1965 Social Security Act authorizing funding for the Medicare Program for the aged, blind, and disabled. The term is interchangeable with "Medicare". (11-10-81)

7~~6~~7. **Title XIX**. That program established by the 1965 Social Security Act authorizing the Medical Assistance Program, commonly referred to as "Medicaid", which is jointly financed by the federal and state governments and administered by the states. The term is interchangeable with "Medicaid". (11-10-81)

7~~7~~8. **Third Party**. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-30-01)

7~~8~~9. **Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-30-01)

~~79~~80. **Utilization Control (UC)**. A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants/participants to Title XIX benefits in a NF. (3-30-01)

8~~0~~1. **Utilization Control Team (UCT)**. A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the NFs approved by the Department as providers of care for eligible medical assistance participants. (3-30-01)

8~~1~~2. **Vocational Services**. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-30-01)

(BREAK IN CONTINUITY OF SECTIONS)

070. PHYSICIAN SERVICES.

01. **Services Provided**. The Department will reimburse for treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Section 065 and Subsection 070.02. All services not specifically included in this chapter are excluded from reimbursement. (12-31-91)

02. **Restriction Of Coverage**. (7-1-93)

a. Out-patient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible recipient in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty-five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. (11-10-81)

b. Particular restrictions pertaining to payment for sterilization procedures are contained in Section 090; and (12-31-91)

c. Restrictions governing payment for abortions are contained in Section 095; and (12-31-91)

d. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed recipients over the age of forty (40). This limitation does not apply to recipients receiving continuing treatment for glaucoma. (10-25-88)

e. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis; and (11-10-81)

f. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis.

Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (11-10-81)

g. Corneal transplants and kidney transplants are covered by the MA program. (5-15-84)

03. Misrepresentation Of Services. Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other nonphysician professional as a physician service is prohibited. (6-1-86)

04. Physician Penalties For Late ~~*PRO*~~ QIO Review. Medicaid will assess the physician a penalty for failure to ~~*have*~~ request a preadmission review from the Department or its designee, for procedures and diagnosis listed on the select list in the Department's Physician Provider Handbook and the QIO Idaho Medicaid Provider Manual, in accordance with Subsection 080.02.a. of these rules and Idaho Department of Health and Welfare Rules, IDAPA 16.03.10, "Rules Governing Provider Reimbursement in Idaho," as amended. ~~*A penalty will be assessed*~~ If a retrospective review determines the procedure was medically necessary, and the physician was late in obtaining a preadmission review the Department will assess a penalty according to Subsection 070.05 entitled "Physician Penalty Chart". The penalty will be assessed after ~~*billing*~~ payment for physician services has occurred. ~~*(3-30-01)*~~(4-1-03)T

05. Physician Penalty Chart. (3-1-92)

a. A request for preadmission ~~*PRO*~~ QIO review that is one (1) day late will result in a penalty of fifty dollars ($50). ~~*(3-30-01)*~~(4-1-03)T

b. A request for preadmission ~~*PRO*~~ QIO review that is two (2) days late will result in a penalty of one hundred dollars ($100). ~~*(3-30-01)*~~(4-1-03)T

c. A request for preadmission ~~*PRO*~~ QIO review that is three (3) days late will result in a penalty of one hundred and fifty dollars ($150). ~~*(3-30-01)*~~(4-1-03)T

d. A request for preadmission ~~*PRO*~~ QIO review that is four (4) days late will result in a penalty of two hundred dollars ($200). ~~*(3-30-01)*~~(4-1-03)T

e. A request for preadmission ~~*PRO*~~ QIO review that is five (5) days late or later will result in a penalty of two hundred and fifty dollars ($250). ~~*(3-30-01)*~~(4-1-03)T

06. Physician Excluded From The Penalty. Any physician who provides care but has no control over the admission, continued stay or discharge of the patient will not be penalized. Assistant surgeons and multi-surgeons are not excluded from the penalty. (3-1-92)

07. Procedures For Medicare Cross-Over Claims. If a MA recipient is eligible for Medicare, the physician must bill Medicare first for the services rendered to the recipient. (11-10-81)

a. If a physician accepts a Medicare assignment, the Department will pay the physician for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the physician automatically based upon the Medicare Summary Notice (MSN) information on the computer tape which is received from the Medicare Part B Carrier on a weekly basis. (5-1-02)T

b. If a physician does not accept a Medicare assignment, a Medicare Summary Notice (MSN) must be attached to the appropriate claim form and submitted to the Department. The Department will pay the physician for the services, up to the Medicaid allowable amount minus the Medicare payment. (5-1-02)T

c. In order for the Department to make payment, the physician must agree to accept the payment from Medicare and Medicaid as payment in full for covered services. (11-10-81)

08. Procedure For Locum Tenens Claims And Reciprocal Billing. (3-15-02)

a. In reimbursement for Locum Tenens/Reciprocal Billing, the patient's regular physician may submit

the claim and receive payment for covered physician services (including emergency visits and related services) provided by a Locum Tenens physician who is not an employee of the regular physician if: (3-15-02)

i. The regular physician is unavailable to provide the visit services. (3-15-02)

ii. The Medicaid patient has arranged for or seeks to receive services from the regular physician. (3-15-02)

iii. The regular physician pays the Locum Tenens for his services on a per diem or similar fee-for-time basis. (3-15-02)

iv. The substitute physician does not provide the visit services to Medicaid patients over a continuous period of longer than ninety (90) days for Locum Tenens and over a continuous period of fourteen (14) days for Reciprocal Billing. (3-15-02)

v. The regular physician identifies the services as substitute physician services meeting the requirements of this Section by appending modifier-Q6 (service furnished by a Locum Tenens physician) to the procedure code or Q5 (services furnished by a substitute physician under Reciprocal Billing arrangements). (3-15-02)

vi. The regular physician must keep on file a record of each service provided by the substitute physician associated with the substitute physician's UPIN, and make this record available to the department upon request. (3-15-02)

vii. The claim identifies (in a manner specified by the department) the physician who furnished the services. (3-15-02)

b. If the only Locum Tenens/Reciprocal billing services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, those services shall not be reported separately on the claim as substitution services, but shall be deemed as included in the global fee payment. (3-15-02)

c. A physician may have Locum Tenens/reciprocal billing arrangements with more than one (1) physician. The arrangements need not be in writing. Locum Tenens/reciprocal billing services need not be provided in the office of the regular physician. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

080. IN-PATIENT HOSPITAL SERVICES.

01. Exceptions And Limitations. The following exceptions and limitations apply to in-patient hospital services: (11-10-81)

a. Payment is limited to semi-private room accommodations. (11-10-81)

i. The Department must not authorize reimbursement for any part of a private room unless the attending physician orders a private room for the patient because of medical necessity. (11-10-81)

ii. If a patient or the family of a patient desires a private room, the party ordering the private room will be responsible for full payment for the private room. (11-10-81)

b. If a MA recipient is eligible for Medicare, the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

c. If services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the EOMB cross-over information. (11-10-81)

d. Hospital care associated with noncovered services as contained in Section 065 is excluded from MA payment. (12-31-91)

02. Payment Procedures. The following procedures are applicable to in-patient hospitals: (11-10-81)

a. The patient's admission and length of stay is subject to preadmission, concurrent and retrospective review by a ~~*Peer Review Organization (PRO)*~~ Quality Improvement Organization (QIO) designated by the Department. ~~*PRO*~~ QIO review will be governed by provisions of the ~~*PRO*~~ QIO Idaho Medicaid Provider Manual as amended. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely ~~*PRO*~~ QIO review as required by Section 080, and as outlined in the ~~*PRO*~~ QIO Idaho Medicaid Provider Manual as amended, will result in the ~~*PRO*~~ QIO conducting a late review. After a ~~*PRO*~~ QIO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in Subsection 080.04 entitled "Hospital Penalty Chart". ~~*(3-1-92)*~~(4-1-03)T

i. All admissions are subject to ~~*PRO*~~ QIO review to determine if continued stay in inpatient status is medically necessary. A ~~*PRO*~~ QIO continued stay review is required when the recipient's length of stay exceeds the number of days certified by the ~~*PRO*~~ QIO. If no initial length of stay certification was issued by the ~~*PRO*~~ QIO, a ~~*PRO*~~ QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. ~~*(3-30-01)*~~(4-1-03)T

ii. Reimbursement for services originally identified as not medically necessary by the ~~*PRO*~~ QIO will be made if such decision is reversed by the appeals process required in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 301, et seq., "Rules Governing Contested Case~~s~~ Proceedings and Declaratory Rulings". ~~*(12-31-91)*~~(4-1-03)T

iii. Absent the Medicaid recipient's informed decision to incur services deemed unnecessary by the ~~*PRO*~~ QIO, or not authorized by the ~~*PRO*~~ QIO due to the negligence of the provider, no payment for denied services may be obtained from the recipient. ~~*(12-3-90)*~~(4-1-03)T

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for in-patient hospital care in accordance with the rules set forth in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho". The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (12-31-91)

c. If a MA recipient is eligible for Medicare the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

i. If services are related to the professional component of laboratory and x-ray services, the payment for Medicare co-insurance and deductible will be made and forwarded to the hospital automatically based upon the EOMB cross-over information. (11-10-81)

ii. For all other services, a Medicare EOMB must be attached to the appropriate claim form and submitted to Medicaid for the billing of Medicare co-insurance and deductible charges. (3-30-01)

d. Diagnostic tests and procedures, including laboratory tests, pathological, and x-ray examinations whether provided on an in-patient or an out-patient basis, are reimbursable only if related to the diagnosis and treatment of a covered medical condition. (12-3-90)

e. Only tests or evaluations specifically ordered by a physician will be reimbursed. (12-3-90)

03. Duties Of The Designated ~~*PRO*~~ QIO. The designated ~~*PRO*~~ QIO ~~*shall*~~ must prepare, distribute and maintain a provider manual~~.~~, ~~*The PRO provider manual shall be distributed by the PRO and*~~ which must be

periodically updated ~~*thereafter*~~. The manual will include, and is not limited to, the following: ~~*(10-1-89)*~~(4-1-03)T

a. The ~~*PRO*~~QIO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. ~~*(10-1-89)*~~(4-1-03)T

b. Department selected diagnoses and elective procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. (10-1-89)

c. A provision that the ~~*PRO*~~ QIO will inform the hospital of a certification within five (5) days, or other time frame as determined by the Department, of an approved admission, transfer, or continuing stay. ~~*(3-30-01)*~~(4-1-03)T

d. The method of notice to hospitals of ~~*PRO*~~ QIO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. ~~*(10-1-89)*~~(4-1-03)T

e. The procedures which providers or recipients will use to obtain reconsideration of a denial by the ~~*PRO*~~ QIO prior to appeal to the Department ~~*in accordance with the provisions of Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Section 301, et seq., "Rules Governing Contested Cases and Declaratory Rulings"*~~. Such requests for reconsideration by the ~~*PRO*~~ QIO must be made in writing to the ~~*PRO*~~ QIO within ~~*sixty*~~ one hundred eighty (~~*6*~~180) days of the issuance of the "Notice of Non-Certification of Hospital Days". ~~*(12-31-91)*~~(4-1-03)T

04. Hospital Penalty Chart. (3-1-92)

a. A request for a preadmission and/or continued stay ~~*PRO*~~ QIO review that is one (1) day late will result in a penalty of two hundred and sixty dollars ($260), from the total Medicaid paid amount of the inpatient hospital stay. ~~*(3-30-01)*~~(4-1-03)T

b. A request for a preadmission and/or continued stay ~~*PRO*~~ QIO review that is two (2) days late will result in a penalty of five hundred and twenty dollars ($520), from the total Medicaid paid amount of the inpatient hospital stay. ~~*(3-30-01)*~~(4-1-03)T

c. A request for a preadmission and/or continued stay ~~*PRO*~~ QIO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars ($780), from the total Medicaid paid amount of the inpatient hospital stay. ~~*(3-30-01)*~~(4-1-03)T

d. A request for a preadmission and/or continued stay ~~*PRO*~~ QIO review that is four (4) days late will result in a penalty of one thousand and forty dollars ($1,040), from the total Medicaid paid amount of the inpatient hospital stay. ~~*(3-30-01)*~~(4-1-03)T

e. A request for a preadmission and/or continued stay ~~*PRO*~~ QIO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars ($1,300), from the total Medicaid paid amount of the inpatient hospital stay. ~~*(3-30-01)*~~(4-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

085. OUT-PATIENT HOSPITAL SERVICES.
On site services eligible for payment include preventive, diagnostic, therapeutic, rehabilitative or palliative items, or services furnished by or under the direction of a physician or dentist, unless excluded by any other provisions of this chapter. (3-22-93)

01. Exceptions And Limitations. (7-1-93)

a. Claims for emergency room service must include a diagnosis and copy of the emergency room

record. (11-10-81)

b. Payment for emergency room service is limited to six (6) visits per calendar year. (11-10-81)

c. Emergency room services which are followed immediately by admission to inpatient status will be excluded from the six (6) visit limit. (11-10-81)

02. Procedures For Medicare Cross-Over Claims. (11-10-81)

a. If an MA recipient is eligible for Medicare, the hospital must first bill Medicare for the services rendered to the recipient. (11-10-81)

b. If the services are related to the professional component of laboratory and x-ray services, the Department will pay the hospital for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the hospital automatically based upon the Medicare Summary Notice (MSN) cross-over information. (5-1-02)T

c. For all other services, a Medicare Summary Notice (MSN) must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. (5-1-02)T

03. Preauthorization For Selected Outpatient Procedures. Failure to obtain a timely review from the Department or its designee prior to delivery of outpatient services, listed on the select procedure and diagnosis list in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook as amended for clients who are eligible at the time of service, will result in a retrospective review. The Department will assess a late review penalty, as outlined in Subsection 080.04 of these rules, when a review is conducted due to an untimely request. (4-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

201. DEFINITIONS.
For purposes of Sections 200 through 233, unless the context clearly requires otherwise, the following words and terms shall have the following meanings: (4-5-00)

01. Abuse Or Abusive. Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or in physical harm, pain or mental anguish to a medical assistance recipient. It also includes recipient practices that result in unnecessary cost to the Medicaid program, or recipient utilization practices which may endanger their personal health or safety. (4-5-00)

02. Claim. Any request or demand for payment of items or services under the state's medical assistance program, whether under a contract or otherwise. (4-5-00)

03. Conviction. An individual or entity is considered to have been convicted of a criminal offense: (3-30-01)

a. When a judgment of conviction has been entered against the individual or entity by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (3-30-01)

b. When there has been a finding of guilt against the individual or entity by a federal, state, or local court; (3-30-01)

c. When a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal,

state, or local court; or (3-30-01)

d. When the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld. (3-30-01)

04. Exclusion. A specific person or provider will be precluded from directly or indirectly providing services and receiving reimbursement under Medicaid. (4-5-00)

05. Fraud Or Fraudulent. An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. (4-5-00)

06. Knowingly, Known, Or With Knowledge. A person, with respect to information or an action, who: has actual knowledge of the information or an action; acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. (4-5-00)

07. Managing Employee. A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. (4-5-00)

08. Medical Assistance. Shall mean payments for part or all of the cost of such care and services allowable within the scope of Title XIX and XXI of the federal Social Security Act as amended as may be designated by Department rules. (4-5-00)

09. Ownership Or Control Interest. A person or entity that: has an ownership interest totaling twenty-five percent (25%) or more in an entity; is an officer or director of an entity that is organized as a corporation; is a partner in an entity that is organized as a partnership; or is a managing member in an entity that is organized as a limited liability company. (4-5-00)

10. Person. An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. (4-5-00)

~~***11. PRO**. Any peer review organization.* (4-5-00)~~

1~~2~~1. Program. The Medicaid Program or any part thereof, including Idaho's state plan. (4-5-00)

1~~3~~2. Recoup And Recoupment. That payment of provider claims will be withheld for the purpose of recovering funds which have been paid for items or services the Department has subsequently determined should not have been paid. (4-5-00)

1~~4~~3. Sanction. Any abatement or corrective action taken by the Department which is appealable under Section 224 of these rules. (4-5-00)

1~~5~~4. State Plan. The Medicaid Program as it exists in Idaho. (4-5-00)

1~~6~~5. Provider Suspension. The temporary barring of a person from participation in the Medicaid program pending further investigation or additional action. (4-5-00)

(BREAK IN CONTINUITY OF SECTIONS)

215. PERMISSIVE EXCLUSIONS.
The Department may exclude any person or entity for a period of not less than one (1) year: (4-5-00)

01. Endangerment Of Health Or Safety Of A Patient. Where there has been a finding by the

Department or ~~*peer review group or organization*~~ Quality Improvement Organization (QIO) of endangering the health or safety of a patient. ~~*(4-5-00)*~~(4-1-03)T

02. Failure To Disclose Or Make Available Records. That has failed or refused to disclose or make available to the Department, or its authorized agent, or any licensing board, any records maintained by the provider or required of the provider to be maintained, which the Department deems relevant to determining the appropriateness of payment. (4-5-00)

03. Other Exclusions. For any reason for which the Secretary of Health and Human Services, or his designee, could exclude an individual or entity. (3-30-01)

(BREAK IN CONTINUITY OF SECTIONS)

222. PUBLIC NOTICE.

The Department will give notice of the action taken and the effective date to the public, appropriate beneficiaries, and may give notice as appropriate, including, but not limited to, related providers, the ~~*PRO*~~ Quality Improvement Organization (QIO), institutional providers, professional organizations, contractors, other health insurance payors, and other agencies or Departmental divisions. ~~*(4-5-00)*~~(4-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0218

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted as proposed. The original text of the proposed rule was published in the December 4, 2002, Idaho Administrative Bulletin, Volume 02-12, pages 128 and 129.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Arla Farmer at (208) 364-1958.

DATED this 9th day of January, 2003.

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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 02-12, December 4, 2002, pages 128 and 129.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0218

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective December 1, 2002.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than December 18, 2002.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Clozapine is a psychotropic medication which requires care coordination and close medical oversight for the client. Currently Clozapine is the only medication for which Medicaid pays a special reimbursement for care coordination. Medicaid has determined that since providers are already reimbursed for managing client care and medications Clozapine Care Coordination should be discontinued.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(c), Idaho Code and are necessary in order to comply with deadlines in amendments to governing law.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because of time constraints and the rulemaking is to comply with judicial order.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Arla Farmer at (208) 364-1958.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before December 25, 2002.

DATED this 10th day of October, 2002.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0218

111. -- 11~~6~~7. (RESERVED).

~~117. CLOZAPINE CARE COORDINATION.~~

~~01. Qualifications~~*~~. The Department will make payments for care coordination services associated with prescribed Clozapine therapy to entities operating manufacturer registered Clozapine treatment systems. (2-19-92)~~*

~~02. Payment Procedures~~*~~. A single payment for each calendar week (or portion thereof) will be made. Payments for care coordination services are made in lieu of payments for chemotherapy visits to mental health centers and/or physician medical management services unless significant identifiable services in excess of those required by the manufacturers registered treatment system are required and documented. The rate of payment will be established in accordance with Subsection 060.04. (2-19-92)~~*

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0301

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), 56-1004(l)(a), Idaho Code.

DESCRIPTIVE SUMMARY: The pending rules are being adopted as proposed. The original text of the proposed rules was published in the January 1, 2003 Administrative Bulletin, Volume 03-1, pages 92 and 93.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Jan Uren at (208) 364-1854.

DATED this 10th day of April, 2003.

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IDAPA 13, TITLE 01, CHAPTER 03

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-01, January 1, 2003, pages 92 and 93.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0301

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective August 1, 2002.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), 56-1004(l)(a), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than January 15, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

The Idaho Medicaid Program will reimburse for out-of-state nursing home placements when services are not available in Idaho to meet the recipient's medical need, or in a temporary situation for limited period of time required to safely transport the recipient to an Idaho facility. This rulemaking is the companion to Docket No. 16-0310-0301.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(c), Idaho Code and are necessary in order to confer a benefit.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because these amendments only clarify, but do not change, existing practice.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Jan Uren at (208) 364-1854.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before January 22, 2003.

DATED this 5th day of November, 2002.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0301

015. CHOICE OF PROVIDERS.

01. Service Selection. Each recipient may obtain any services available from any participating institution, agency, pharmacy, or practitioner of his choice, unless enrolled in a coordinated care plan. This, however, does not prohibit the Department from establishing the fees which will be paid to providers for furnishing medical and remedial care available under the MA Program, or from setting standards relating to the qualifications of providers of such care. (6-1-94)

02. Lock-In Option. (7-1-93)

a. The Department may implement a total or partial lock-in program for any recipient found to be misusing the MA Program according to provisions in Sections 226 through 233 of these rules; but (3-30-01)

b. In situations where the recipient has been restricted to a recipient lock-in program, that recipient may choose the physician and pharmacy of his choice. The providers chosen by the lock-in recipient will be identified in the Department's Eligibility Verification System (EVS). This information will be available to any Medicaid provider who accesses the EVS. (7-1-98)

03. 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. (3-30-01)

a. If payment is requested for transportation costs to receive the out-of-state medical care, the Department or its designee will determine if appropriate, comparable medical care is available closer to the recipient's residence. If such care is available, the Department or its designee will limit authorization to payment for transportation costs associated with a trip to the closer location. If it is determined necessary and appropriate for the medical care to be rendered at the out-of-state location, then the Department or its designee will authorize payment for transportation costs associated with a trip to the out-of-state location. Transportation costs to receive out-of-state medical care requires authorization pursuant to Section 150. (3-30-01)

b. ~~*Long-term care outside the State may be approved by the Department on an individual basis in temporary or emergency situations. Nursing home care will be limited to the period of time required to safely transport the recipient to an Idaho facility. Out-of-state care will not be approved on a permanent basis.*~~ The Idaho Medicaid Program will reimburse for out-of-state nursing home placements when services are not available in Idaho to meet the recipient's medical need, or in a temporary situation for a limited period of time required to safely transport the recipient to an Idaho facility. ~~*(11-10-81)*~~(8-1-02)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0303

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is May 12, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule.

This rule is being amended in response to information received during the comment period and consultation between the Legislative Task Force and Department staff. It was clarified in Section 814 that the Pharmacy and Therapeutics Committee (P&T) members are appointed by the Director of the Department, the functions of the P&T Committee are more fully described, and text was added to explain under what circumstances the P&T Committee may adjourn to executive session while meeting. Text was deleted in Section 815 to simplify and clarify factors to be considered in determining exemptions from prior authorization.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the August 6, 2003 Administrative Bulletin, Volume 03-08, pages 68 and 69.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Chris Baylis at (208) 364-1831.

DATED this 22nd day of October, 2003.

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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-8, August 6, 2003, pages 68 and 69.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

Language That Has Been Deleted From The Original Proposed Rule Has Been Removed And New Language Is Shown In Italics

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THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0309-0303

SECTIONS 814 AND 815 (Entire Sections)

814. PHARMACY AND THERAPEUTICS COMMITTEE (P&T Committee).

01. Membership. The P&T Committee is appointed by the Director and is composed of practicing pharmacists, physicians and other licensed health care professionals with authority to prescribe medications. ~~*(5-12-03)T*~~(5-12-03)T

02. Function. The P&T Committee ~~*will serve in an advisory capacity to the Department*~~ has the following responsibilities for the prior authorization of drugs under Subsection 810.01.e. of these rules: ~~*and will recommend to the Department the classes of medications to be reviewed through an evidence-based evaluation.*~~ ~~*(5-12-03)T*~~(5-12-03)T

a. To serve in evaluational, educational and advisory capacities to the Idaho Medicaid Program specific to the prior authorization of drugs with therapeutically interchangeable alternatives. (5-12-03)T

b. To receive evidence-based clinical and pharmacoeconomic data and recommend to the Department the agents to be exempt from prior authorization in selected classes of drugs with therapeutically interchangeable alternatives. The recommendation of items to be exempt from prior authorization will be based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, and secondarily on cost. (5-12-03)T

c. To recommend to the Department the classes of medications to be reviewed through evidence-based evaluation. (5-12-03)T

d. To review drug utilization outcome studies and intervention reports from the Drug Utilization

Review Board as part of the process of reviewing and developing recommendations to the Department. (5-12-03)T

03. **Meetings**. The P&T Committee meetings will be open to the public and a portion of each meeting will be set aside to hear and review public comment. The P&T Committee may adjourn to executive session to consider the following: ~~*(5-12-03)T*~~(5-12-03)T

a. Relative cost information for prescription drugs that could be used by representatives of pharmaceutical manufacturers or other people to derive the proprietary information of other pharmaceutical manufacturers; or (5-12-03)T

b. Participant-specific or provider-specific information. (5-12-03)T

815. SUPPLEMENTAL REBATES.

01. **Purpose**. The purpose of supplemental rebates is to enable the Department to purchase prescription drugs provided to Medicaid beneficiaries in a cost effective manner, whether or not these drugs are subject to prior authorization by the Department. The supplemental rebate may be one factor considered in exempting a prescription drug from prior authorization, but is secondary to considerations of the safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs~~*, and the net economic impact of inclusion or exclusion of the drug from prior authorization*~~. ~~*(5-12-03)T*~~(5-12-03)T

02. **Rebate Amount**. The Department or its designee may negotiate with manufacturers supplemental rebates for prescription drugs that are in addition to those required by Title XIX of the Social Security Act. There is no upper limit on the dollar amounts of the supplemental rebates the Department may negotiate. (5-12-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0303

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective May 12, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section(s) 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 20, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Two new sections are added to the Medical Assistance rules dealing with pharmacy issues. The new sections provide guidelines for a Pharmacy and Therapeutics Committee and supplemental drug rebates.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to protect the public health, safety and welfare.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because information was obtained during other rule hearings pertaining to this rule subject and discussion during the 2003 Legislative session added to the formation of this new docket.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Chris Baylis at (208) 361-1831.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before August 27, 2003.

DATED this 12th day of June, 2003.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0303

~~***814. 815. (RESERVED).***~~

814. PHARMACY AND THERAPEUTICS COMMITTEE (P&T Committee).

01. Membership. The P&T Committee is composed of practicing pharmacists, physicians and other licensed health care professionals with authority to prescribe medications. (5-12-03)T

02. Function. The P&T Committee will serve in an advisory capacity to the Department for the prior authorization of drugs under Subsection 810.01.e. of these rules and will recommend to the Department the classes of medications to be reviewed through an evidence-based evaluation. (5-12-03)T

03. Meetings. The P&T Committee meetings will be open to the public and a portion of each meeting will be set aside to hear and review public comment. (5-12-03)T

815. SUPPLEMENTAL REBATES.

01. Purpose. The purpose of supplemental rebates is to enable the Department to purchase prescription drugs provided to Medicaid beneficiaries in a cost effective manner, whether or not these drugs are subject to prior authorization by the Department. The supplemental rebate may be one factor considered in exempting a prescription drug from prior authorization, but is secondary to considerations of the safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, and the net economic impact of inclusion or exclusion of the drug from prior authorization. (5-12-03)T

02. Rebate Amount. The Department or its designee may negotiate with manufacturers supplemental rebates for prescription drugs that are in addition to those required by Title XIX of the Social Security Act. There is no upper limit on the dollar amounts of the supplemental rebates the Department may negotiate. (5-12-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0304

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is October 20, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

HIPAA Release 2 implementation is October 20, 2003. The changes necessary for compliance with this implementation are being made to the temporary rule and pending rule with the effective date of October 20, 2003.

Pursuant to Section 67-5228, Idaho Code, typographical, transcriptional, and/or clerical corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes differ from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the August 6, 2003 Idaho Administrative Bulletin, Volume 03-8, pages 69 through 91.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Arla Farmer at (208) 364-1958.

DATED this 29th day of September, 2003.

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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-8, August 6, 2003, pages 69 through 91.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0309-0304

SUBSECTION 906.02 (Partial Section and Partial Table)

906. PROSTHODONTICS.

02. Removable Prosthodontics By Codes.

TABLE 906.02 - PROSTHODONTICS	
Dental Code	**Description**
g. Other Removable Prosthetic Services.	
D5850	Tissue conditioning, maxillary - per denture unit.
D5851	Tissue conditioning, mandibular per denture unit.
D5899	Unspecified removable prosthetic procedure, by report. Narrative required when prior authorizing. Requires prior authorization.
~~0515~~D5899	Unable to deliver full or partial denture. Prior authorization required. If the client does not complete the process for the denture; leaves the state; cannot be located; or dies; the laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

~~(7-1-03)T~~(10-20-03)T

SUBSECTION 913.03 (Partial Section)

913. DENTURIST POLICY GUIDELINES.

03. Prior Authorization. Prior authorization is not required for the denturist procedures except for dental code ~~0515~~D5899 found in Section 914 of these rules. ~~(7-1-03)T~~(10-20-03)T

SECTION 914 (Entire Section)

914. DENTURIST PROCEDURE CODES.
The following codes are valid denturist procedure codes:

TABLE 914 - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
D5110~~D~~	Complete denture, upper
D5120~~D~~	Complete denture, lower
D5130~~D~~	Immediate denture, upper
D5140~~D~~	Immediate denture, lower
D5410~~D~~	Adjust complete denture, upper
D5411~~D~~	Adjust complete denture, lower
D5421~~D~~	Adjust partial denture, upper
D5422~~D~~	Adjust partial denture, lower
D5510~~D~~	Repair broken complete denture base; arch designation required.
D5520~~D~~	Replace missing or broken teeth, complete denture (each tooth); six (6) teeth maximum. Tooth designation required.
D5610~~D~~	Repair resin saddle or base; arch designation required.
D5620~~D~~	Repair cast framework; arch designation required.
D5630~~D~~	Repair or replace broken clasp; arch designation required.
D5640~~D~~	Replace broken teeth per tooth; tooth designation required.
D5650~~D~~	Add tooth to existing partial denture; tooth designation required.
D5660~~D~~	Add clasp to existing partial denture; not requiring the altering of oral tissue or natural teeth. Tooth designation required.
D5730~~D~~	Reline complete upper denture (chairside)
D5731~~D~~	Reline complete lower denture (chairside)
D5740~~D~~	Reline upper partial denture (chairside)
D5741~~D~~	Reline lower partial denture (chairside)
D5750~~D~~	Reline complete upper denture (laboratory)
D5751~~D~~	Reline complete lower denture (laboratory)
D5760~~D~~	Reline upper partial denture (laboratory)
D5761~~D~~	Reline lower partial denture (laboratory)
~~0515~~D5899	Unable to deliver full denture. Prior authorization required. If the client does not complete the process for the denture, leaves the state, cannot be located or dies, laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.

~~(7-1-03)T~~(10-20-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0304

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 20, 2003**.**

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

These rules are required to comply with 2003 Legislative Intent language as described in the Department's Appropriations Bill, that defines Medicaid dental coverage for adults (persons 21 years of age or older). Rule changes were initially completed in Docket 16-0309-0302, however, these rules were temporary rules for the 2003 Budget. After conferring with Legislative Committees, Medicaid's dental consultants and working with the Idaho Dental Association, the Legislative Intent for the 2004 Budget was to remove the requirement that clients must be considered high risk or in need of emergency dental services.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. Public comment should be addressed to these additions and deletions.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted with the Idaho Dental Association through the 2003 Legislative Committee hearings.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Arla Farmer at (208) 364-1958.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before August 27, 2003.

DATED this 23rd day of June, 2003.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0304

900. DENTAL SERVICES.

01. Dental Services Provided. Dental services are provided for the relief of dental pain, prosthetic replacement, and the correcting of handicapping malocclusion and are purchased from a licensed dentist or denturist. A Medicaid dental consultant will review requests for prior authorization, with accompanying documentation, to determine approval or denial. (3-15-02)

02. Covered Dental ~~***Covered Benefits And Limitations***~~ **Services**. Dental services are covered by Medicaid ~~*with specific limitations and exclusions*~~ as described in Subsections 900.02.a. through 900.02.c. of these rules. Idaho uses the procedure codes contained in the ~~*most recent*~~ Current Dental Terminology (CDT) handbook published by the American Dental Association. ~~*(3-15-02)*~~(7-1-03)T

a. Covered dental services for children (through the month of their twenty-first birthday) are covered in Sections 900 through 914 and Section 916 of these rules. (7-1-03)T

b. Dental services for women on the Pregnant Women and Children (PWC) Program are listed in Section 912 of these rules. (7-1-03)T

c. Covered dental services for Medicaid eligible adults (persons who are past the month of their twenty-first birthday) who are not eligible under PWC or Qualified Medicare Beneficiary (QMB) are listed in Section 915 of these rules. (7-1-03)T

03. Customary Fees. Medicaid reimburses dentists for procedures on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. Dentists may make arrangements for private payment with families for services not covered by Medicaid. If the provider accepts any Medicaid payment for a covered service, the Medicaid payment must be accepted as payment in full for the service, and the client cannot be billed for the difference between the billed amount and the Medicaid allowed amount. ~~*(3-15-02)*~~(7-1-03)T

04. Non-Covered Services. Non-covered services are procedures not recognized by the American Dental Association (ADA) ~~*and/*~~or services not listed in these rules. ~~*(3-15-02)*~~(7-1-03)T

901. DENTAL DIAGNOSTIC PROCEDURES.
~~*The following examinations are not allowed in combination of the same day:*~~
:

TABLE 901 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
01. General Oral Evaluations. The following evaluations are not allowed in combination of the same day:	
D0120	Periodic oral evaluation. Includes periodontal screening. One (1) periodic examination is allowed every six (6) months.
D0140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem. Not to be used when a client returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.
D0150	Comprehensive oral evaluation. One (1) comprehensive examination is allowed every twelve (12) months. Six (6) months must elapse before a periodic exam can be paid.

TABLE 901 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
D0160	Detailed and extensive oral evaluation. A detailed and extensive problem focused evaluation that entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. One (1) detailed and extensive oral evaluation is allowed every twelve (12) months.
D0170	Re-evaluation, limited, problem focused. Established client, not post-operative visit.
02. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series (including bitewings). Complete series x-rays are allowed only once in a three-year period. A complete intraoral series consists of fourteen (14) periapicals and one (1) series of four (4) bitewings.
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
D0240	Intraoral occlusal film.
D0270	Bitewing - single film. Total of four (4) bitewings allowed every six (6) months.
D0272	Bitewings - two (2) films. Total of four (4) bitewings allowed every six (6) months.
D0274	Bitewings - four (4) films. Total of four (4) bitewings allowed every six (6) months.
D0277	Vertical bitewings. ~~*Total of four (4) bitewings*~~ Seven (7) to eight (8) films. ~~a~~Allowed every six (6) months.
D0330	Panoramic film. Panorex, panelipse or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a thirty-six-month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four bitewings or periapicals are allowed in addition to a panoramic film.
D0340	Cephalometric film. Allowed once in a twelve-month period.
03. Test And Laboratory Examination.	
D0460	Pulp vitality tests. Includes multiple teeth and contralateral comparison(s) as indicated. Allowed once per visit per day. ~~*Limited to six (6) teeth per visit.*~~
D0470	Diagnostic casts.
~~*D0501*~~	~~*Histopathologic examinations.*~~
04. Diagnostic.	
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.

~~*(3-15-02)*~~(7-1-03)T

902. DENTAL PREVENTIVE PROCEDURES.
Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

TABLE 902 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
01. Dental Prophylaxis.	

TABLE 902 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
D1110	Prophylaxis - Adult (twelve (12) years of age and older). A prophylaxis is allowed once every six (6) months. Includes polishing procedures to remove coronal plaque, calculus, and stains.
D1120	Prophylaxis - Children/young adult (under age twelve (12)). A prophylaxis is allowed once every six (6) months.
02. Fluoride Treatments.	
D1203	Topical application of fluoride - one (1) treatment. Prophylaxis not included. Allowed once every six (6) months for clients under age twenty (21).
D1204	Topical application of fluoride - adult, twenty-one (21) years of age and over. Prophylaxis not included. Allowed once every six (6) months.
03. Other Preventive Services.	
D1351	Sealant - per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for clients under twenty-one (21) years of age. Limited to once per tooth every three (3) years. Tooth designation required.
04. Space Management Therapy. Space maintainers are allowed to hold space for missing teeth for clients under age twenty-one (21). No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.	
D1510	Space maintainer - fixed - unilateral. Limited up to age twenty-one (21). Only allowed once per tooth space. Tooth space designation required.
D1515	Space maintainer - fixed - bilateral. Limited up to age twenty-one (21). Only allowed once per arch. Arch designation required.
D1520	Space maintainer, removable - unilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1525	Space maintainer, removable - bilateral. Allowed once every two (2) years up to twenty-one (21) years of age. Arch designation required.
D1550	Re-cementation of space maintainer. Limited up to age twenty-one (21). Only allowed once per quadrant or arch. Quadrant or arch designation required.

~~*(3-15-02)*~~(7-1-03)T

903. DENTAL RESTORATIVE PROCEDURES.
All restorations must be documented in the client's record to include: procedure, surface, and tooth number (if applicable). This record must be maintained for a period of five (5) years. (3-15-02)

01. Posterior Restoration. (3-15-02)

a. A one (1) surface posterior restoration is one in which the restoration involves only one (1) of the five (5) surface classifications: mesial, distal, occlusal, lingual, or facial (including buccal or labial). (3-15-02)

b. A two (2) surface posterior restoration is one in which the restoration extends to two (2) of the five (5) surface classifications. (3-15-02)

c. A three (3) surface posterior restoration is one in which the restoration extends to three (3) of the five (5) surface classification surface classifications. (3-15-02)

d. A four (4) or more surface posterior restoration is one in which the restoration extends to four (4) or more of the five (5) surface classifications. (3-15-02)

02. Anterior Proximal Restoration. (3-15-02)

a. A one (1) surface anterior proximal restoration is one in which neither the lingual nor facial margin of the restoration extends beyond the line angle. (3-15-02)

b. A two (2) surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle. (3-15-02))

c. A three (3) surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle. (3-15-02)

d. A four (4) or more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. (3-15-02)

03. Amalgams And Resin Restoration. (3-15-02)

a. Reimbursement for pit restoration is allowed as a one (1) surface restoration. (3-15-02)

b. Adhesives (bonding agents), bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration. (3-15-02)

c. Liners and bases are included as part of the restoration. If pins are used, they should be reported separately. (3-15-02)

04. Crowns. (3-15-02)

a. When submitting for prior authorization, either an x-ray showing the root canal or an x-ray with a justification detailing the reason for the crown is required. (3-15-02)

b. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (3-15-02)

~~**c.** *Prosthodontics, fixed, procedure codes 06210 through 06920 are not Medicaid covered benefits.* *(3-15-02)*~~

05. Restorations By Codes. (3-15-02)

TABLE 903.05~~.a.~~ - RESTORATION BY CODES	
Dental Code	**Description**
a. Amalgam Restorations.	
~~*D2110*~~	~~*Amalgam - one (1) surface, primary. Tooth designation required.*~~
~~*D2120*~~	~~*Amalgam - two (2) surfaces, primary. Tooth designation required.*~~
~~*D2130*~~	~~*Amalgam - three (3) surfaces, primary. Tooth designation required.*~~
~~*D2131*~~	~~*Amalgam - four (4) or more surfaces, primary. Tooth designation required.*~~
D2140	Amalgam - one (1) surface, primary or permanent. Tooth designation required.
D2150	Amalgam - two (2) surfaces, primary or permanent. Tooth designation required.
D2160	Amalgam - three (3) surfaces, primary or permanent. Tooth designation required.
D2161	Amalgam - four (4) or more surfaces, primary or permanent. Tooth designation required.

TABLE 903.05~~.a.~~ - RESTORATION BY CODES	
Dental Code	**Description**
~~***TABLE 903.05.b. - RESIN RESTORATIONS***~~	
b. Resin Restorations. Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are part of the restoration. Report glass ionomers when used as restorations. If pins are used, report them separately.	
D2330	Resin - one (1) surface, anterior. Tooth designation required.
D2331	Resin - two (2) surfaces, anterior. Tooth designation required.
D2332	Resin - three (3) surfaces, anterior. Tooth designation required.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior. Tooth designation required.
~~*D2337*~~	~~*Resin based composite crown, anterior - permanent. Tooth designation required.*~~
~~*D2380*~~	~~*Resin - one (1) surface, posterior - primary. Tooth designation required. Not a preventive procedure.*~~
~~*D2381*~~	~~*Resin - two (2) surfaces, posterior - primary. Tooth designation required.*~~
~~*D2382*~~	~~*Resin - three (3) or more surfaces, posterior - primary. Tooth designation required.*~~
~~*D2385*~~	~~*Resin - one (1) surface, posterior - permanent. Tooth designation required. Not a preventive procedure.*~~
~~*D2386*~~	~~*Resin - two (2) surfaces, posterior - permanent. Tooth designation required.*~~
~~*D2387*~~	~~*Resin - three (3) surfaces, posterior - permanent. Tooth designation required.*~~
~~*D2388*~~	~~*Resin based composite - four (4) or more surfaces, posterior - permanent. Tooth designation required.*~~
D2390	Resin based composite crown, anterior, primary or permanent. Tooth designation required.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
~~***TABLE 903.05.c. - CROWNS***~~	
c. Crowns.	
D2710	Crown resin ~~*(laboratory)*~~ indirect. Tooth designation required. Prior authorization required.
D2721	Crown resin with predominantly base metal. Tooth designation required. Prior authorization required.
D2750	Crown, porcelain fused to high noble metal. Tooth designation required. Prior authorization required.
D2751	Crown porcelain fused too predominantly base metal. Tooth designation required. Prior authorization required.
D2752	Crown, porcelain fused to noble metal. Tooth designation required. Prior authorization required.
D2790	Crown, full cast, high noble metal. Tooth designation required. Prior authorization required.
D2791	Crown full cast predominantly base metal. Tooth designation required. Prior authorization required.

TABLE 903.05~~.a.~~ - RESTORATION BY CODES	
Dental Code	**Description**
D2792	Crown, full cast noble metal. Tooth designation required. Prior authorization required.
~~***TABLE 903.05.d. - OTHER RESTORATIVE SERVICES***~~	
d. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2930	Prefabricated stainless steel crown - primary tooth. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth. Tooth designation required.
D2932	Prefabricated resin crown. Tooth designation required.
D2940	Sedative filling. Tooth designation required. Surface is not required.
D2950	Core buildup, including any pins. Tooth designation required. Limited to two (2) pins per tooth.
D2951	Pin retention - per tooth, in addition to restoration. Tooth designation required. Limited to two (2) pins per tooth.
D2954	Prefabricated post and core in addition to crown. Tooth designation required.
D2955	Post removal. Tooth designation required.
D2980	Crown repair. Tooth designation required..
D2999	Unspecified restorative procedure, by report. Narrative and tooth designation required when prior authorizing. Requires prior authorization.

~~*(3-15-02)*~~(7-1-03)T

904. ENDODONTICS.
Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth.

TABLE 904 - ENDODONTICS	
Dental Code	**Description**
01. Pulp Capping.	
D3110	Pulp cap - direct (excluding final restoration). Tooth designation required.
02. Pulpotomy.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required. Not to be construed as the first ~~*step*~~ stage of root canal therapy.
D3221	~~*Gross p*~~Pulpal debridement, primary & permanent teeth. For relief of acute pain ~~*prior to conventional*~~ not to be construed as the first stage of root canal therapy. Not allowed same day as endodontic therapy. Tooth designation required.
03. Root Canal Therapy. Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures and follow-up care) is for permanent teeth only. Separate charges are allowable for open and drain if the procedure is done on different days.	
D3310	Anterior (excluding final restoration). Tooth designation required.

TABLE 904 - ENDODONTICS	
Dental Code	**Description**
D3320	Bicuspid (excluding final restoration). Tooth designation required.
D3330	Molar (excluding final restoration). Tooth designation required.
D3346	Retreatment of previous root canal therapy, anterior. Tooth designation required.
D3347	Retreatment of previous root canal therapy, bicuspid. Tooth designation required.
D3348	Retreatment of previous root canal therapy, molar. Tooth designation required.
04. Apicoectomy/Periradicular Services.	
D3410	Apicoectomy/Periradicular surgery-anterior surgery or root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.
D3421	Apicoectomy/Periradicular surgery-bicuspid (first root). Surgery on one root of a bicuspid does not include placement of retrograde filling material. Tooth designation required.
D3425	Apicoectomy/Periradicular surgery-Molar (first root). Does not include placement of retrograde filling material. Tooth designation required.
D3426	Apicoectomy/Periradicular surgery (each additional root). For molar surgeries when more than one root is being treated during the same procedure. Does not include retrograde filling material placement. Tooth designation required.
D3430	Retrograde filling - per root. For placement of retrograde filling material during Periradicular surgery procedures. Tooth designation required.
D3999	Unspecified restorative procedure, by report. Narrative and tooth designation required. Requires prior authorization.

~~*(3-15-02)*~~(7-1-03)T

905. PERIODONTICS.

TABLE 905 - PERIODONTICS	
Dental Code	**Description**
01. Surgical Services.	
D4210	Gingivectomy or gingivoplasty - four (4) or more contiguous teeth in quadrant. Quadrant designation required.
D4211	Gingivectomy or gingivoplasty - ~~*per tooth*~~ one (1) to three (3) teeth in quadrant. ~~*Tooth*~~ Quadrant designation required.
~~*D4220*~~	~~*Gingival curettage, surgical, per quadrant. Designate quadrant.*~~
02. Non-surgical Periodontal Services.	
D4320	Provisional splinting - intracoronal.
D4321	Provisional splinting - extracoronal.
D4341	Periodontal scaling and root planing four (4) or more contiguous teeth ~~(~~per quadrant~~)~~. Allowed once in a twelve (12) month period. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.

TABLE 905 - PERIODONTICS	
Dental Code	**Description**
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve (12) month period. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. Allowed once in a twelve (12) month period. The removal of subgingival and/or supragingival plaque and calculus. This is a preliminary procedure and does not preclude the need for other procedures.
03. Other Periodontal Services.	
D4910	Periodontal maintenance procedures ~~*(following active therapy)*~~. Allowed once in a three (3) month period. This procedure is for clients who have completed periodontal treatment (surgical and/or non-surgical periodontal therapies exclusive of D4355) and includes removal of the bacterial flora from crevicular and pocket areas, scaling and polishing of the teeth, periodontal evaluation, and a review of the client's plaque control efficiency.
D4999	Unspecified periodontal procedure. Narrative required when prior authorizing. Requires prior authorization.

~~*(3-15-02)*~~(7-1-03)T

906. PROSTHODONTICS.

01. Removable Prosthodontics. (3-15-02)

a. The Medicaid dental program covers only one (1) set of full dentures in a five (5) year period. Full dentures placed immediately must be of structure and quality to be considered the final set. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions. (3-15-02)

b. If full dentures are inserted during a month when the client is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. (3-15-02)

c. Medicaid pays for partial dentures once every five (5) years. Partial dentures are limited to clients age twelve (12) and older. One (1) partial per arch is covered. When a partial is inserted during a month when the client is not eligible but all other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed. ~~*(3-15-02)*~~(7-1-03)T

~~***d.*** *Laboratory and professional fees may be paid for a partial or complete denture if the client: Decides not to complete the partial or complete denture; Leaves the state; Cannot be located; Expires. An invoice listing lab and professional fees is required when prior authorizing.* *(3-15-02)*~~

02. Removable Prosthodontics By Codes.

TABLE 906.02 - PROSTHODONTICS	
Dental Code	**Description**
a. Complete Dentures. This includes six (6) months of adjustments following placement.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.

TABLE 906.02 - PROSTHODONTICS	
Dental Code	**Description**
b. Partial Dentures. This includes six (6) months of care following placement. Limited to twelve (12) years and older.	
D5211	Maxillary partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5212	Mandibular partial denture - resin base. Includes any conventional clasps, rests, and teeth.
D5213	Maxillary partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
D5214	Mandibular partial denture - cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
c. Adjustments To Complete And Partial Dentures. No allowance for adjustments for six (6) months following placement. Adjustments done during this period are included in complete/partial allowance.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
d. Repairs To Complete Dentures.	
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth - complete denture (each tooth) - six (6) tooth maximum. Tooth designation required.
e. Repairs To Partial Dentures.	
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
f. Denture Relining. Relines will not be allowed for six (6) months following placement of denture and then only once every two (2) years.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).

TABLE 906.02 - PROSTHODONTICS	
Dental Code	**Description**
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
g. Other Removable Prosthetic Services.	
D5850	Tissue conditioning, maxillary - per denture unit.
D5851	Tissue conditioning, mandibular per denture unit.
D5899	Unspecified removable prosthetic procedure, by report. Narrative required when prior authorizing. Requires prior authorization.
0515D	Unable to deliver full or partial denture. ~~*Laboratory cost may be paid. An*~~ Prior authorization required. If the client does not complete the process for the denture; leaves the state; cannot be located; or dies; the laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation ~~*required when prior authorizing*~~.

~~*(3-15-02)*~~(7-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

909. ORAL SURGERY.
Extraction codes include services for local anesthesia and routine preoperative and postoperative care.

TABLE 909 - ORAL SURGERY	
Dental Code	**Description**
01. Simple Extraction.	
~~*D7110*~~	~~*Single tooth. Tooth designation required.*~~
D7111	Extraction, coronal remnants - deciduous tooth. Including soft-tissue retained coronal remnants.
~~*D7120*~~	~~*Each additional tooth. Tooth designation required.*~~
~~*D7130*~~	~~*Root removal - exposed roots. Tooth designation required.*~~
D7140	Extraction, erupted tooth or exposed root, routine removal.
02. Surgical Extractions.	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Tooth designation required.
D7220	Removal of impacted tooth - soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth -- partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.

TABLE 909 - ORAL SURGERY	
Dental Code	**Description**
D7240	Removal of impacted tooth - completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
03. Other Surgical Procedures.	
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. ~~*Permanent teeth only.*~~ Tooth designation required. Includes splinting and/or stabilization.
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required. Limited to clients under twenty-one (21) years of age.
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption. Tooth designation required. Limited to clients under twenty-one (21) years of age.
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
D7287	Cytology sample collection via mild scraping of oral mucosa.
04. Alveoloplasty.	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant. Quadrant designation is required.
05. Excision Of Bone Tissue.	
D7471	Removal of lateral exostosis. Maxilla or mandible. Arch designation required.
06. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
07. Repair Of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
08. Other Repair Procedures.	
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure. The frenum may be excised when the tongue has limited mobility; for large diastema between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.
D7970	Excision of hyperplastic tissue - per arch. Arch designation required.
D7971	Excision of pericoronal gingiva. Arch designation required.
D7999	Unspecified oral surgery, by report. Narrative required when prior authorizing. Requires prior authorization.

~~*(3-15-02)*~~(7-1-03)T

910. ORTHODONTICS.

01. Orthodontics. Limited to clients age zero (0) to twenty-one (21) years who meet the eligibility requirements, and the Handicapping Malocclusion Index as evaluated by the ~~S~~state Medicaid dental consultant. ~~*Transfers:*~~ Clients already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the ~~S~~state Medicaid dental consultant~~s~~. ~~*(3-15-02)*~~(7-1-03)T

TABLE 910~~.02~~ - ~~*LIMITED*~~ ORTHODONTICS	
Dental Code	**Description**
02. Limited Orthodontics. Orthodontic treatment with a limited objective, not involving the entire dentition may be directed at the only existing problem, or one aspect of a larger problem in which a decision is made to defer or forgo more comprehensive therapy.	
D8010	Limited orthodontic treatment of primary dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8020	Limited orthodontic treatment of transitional dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8030	Limited orthodontic treatment of adolescent dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
D8040	Limited orthodontic treatment of adult dentition. Justification and treatment plan required when prior authorizing. Requires prior authorization.
~~*03. Interceptive Orthodontics.*~~ ~~*Treatment, using codes for interceptive orthodontic treatment, is for procedures to lessen the severity of future effects of a malformation and to eliminate its cause. An extension of preventive orthodontics that may include localized tooth movement in an otherwise normal dentition. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite, or recovery of recent minor space loss where overall space is adequate.*~~	
~~*TABLE 910.03 INTERCEPTIVE ORTHODONTICS*~~	
~~*D8050*~~	~~*Interceptive orthodontic treatment of primary dentition, per arch. Justification, treatment plan and arch designation required when prior authorizing. Upper and lower arch may be billed separately. Indicate arch. Requires prior authorization.*~~
~~*D8060*~~	~~*Interceptive orthodontic treatment of transition dentition, per arch. Justification, treatment plan and arch designation required when prior authorizing. Upper and lower arch may be billed separately. Indicate arch. Requires prior authorization.*~~
0~~4~~3. Comprehensive Orthodontic Treatment. The coordinated diagnosis and treatment leading to the improvement of a client's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. Must score at least eight (8) points on the State's Handicapping Malocclusion Index.	
~~*TABLE 910.04 - COMPREHENSIVE ORTHODONTIC TREATMENT*~~	
D8070	Comprehensive orthodontic treatment of transition dentition. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.
D8080	Comprehensive orthodontic treatment of adolescent dentition, up to sixteen (16) years of age. Models, panorexes, and treatment plan are required when prior authorizing. Requires prior authorization.

TABLE 910~~.02~~ - ~~LIMITED~~ ORTHODONTICS	
Dental Code	**Description**
D8090	Comprehensive orthodontic treatment of adult dentition. Justification required. Models, panoramic film, and treatment plan are required when prior authorizing. Requires prior authorization.
0~~5~~4. Minor Treatment To Control Harmful Habits.	
~~*TABLE 910.05 - MINOR TREATMENT TO CONTROL ORTHODONTIC TREATMENT*~~	
D8210	Removable appliance therapy. Removable indicates client can remove; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
D8220	Fixed appliance therapy. Fixed indicates client cannot remove appliance; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two (2) adjustments when prior authorizing. Replacement appliances are not covered. Requires prior authorization.
0~~6~~5. Other Services.	
~~*TABLE 910.06 - OTHER SERVICES*~~	
D8670	Adjustments monthly. When utilizing treatment codes D8050, D8060, D8070, D8080 or D8090 a maximum of 24 adjustments over two (2) years will be allowed (twelve (12) per year) when prior authorizing. When utilizing treatment codes D8210 or D8220, two (2) adjustments will be allowed per treatment when prior authorizing. Requires prior authorization.
D8680	Orthodontic retention, removal of appliances, construction and placement of retainer(s). Replacement appliances are not covered. Includes both upper and lower retainer if applicable.
D8691	Repair of orthodontic appliance. Limited to one (1) occurrence.
D8999	Unspecified orthodontics. Narrative required when prior authorizing. No payment for lost or destroyed appliances. Requires prior authorization.

~~*(3-15-02)*~~(7-1-03)T

911. ADJUNCTIVE GENERAL SERVICES.

TABLE 911 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
01. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedure (open and drain abscess, etc.). Open and drain is included in the fee for root canal when performed during the same sitting. Tooth or quadrant designation required.
02. Anesthesia.	
D9220	Deep sedation/~~G~~general anesthesia - first thirty (30) minutes. Not included as general anesthesia are tranquilization; nitrous oxide; or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents.
D9221	Deep sedation/~~G~~general anesthesia - each additional fifteen (15) minutes.

TABLE 911 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes. Provider certification required.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes. Provider certification required.
03. Professional Consultation.	
D9310	Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the client's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the client's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
04. Professional Visits.	
D9410	House/Extended Care Facility Calls. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per client. To be used when client's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code D9420.
D9420	Hospital Calls. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited once per day per client. Not covered for routine preoperative and postoperative. If procedures are done in other than hospital or surgery center use procedure code D9410 found in this table.
D9430	Office visit for observation (during regularly scheduled hours). No other services performed.
D9440	Office visit after regularly scheduled hours.
05. Miscellaneous Service.	
D9920	Behavior Management. May be reported in addition to treatment provided when the client is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. Notation and justification must be written in the client's record identifying the specific behavior problem and the technique used to manage it. Allowed once per client per day.
D9930	Treatment of complication (post-surgical) - unusual circumstances.
D9940	Occlusal guards - removable dental appliances which are designed to minimize the effects of bruxism (tooth grinding) and other occlusal factors. No payment for replacement of lost or destroyed appliances.
D9951	Occlusal adjustment, limited. May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a per-visit basis. Allowed once every twelve (12) months.

TABLE 911 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
D9952	Occlusal adjustment, complete. Occlusal adjustment may require several appointments of varying length and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be used for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma, when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma. Justification required when prior authorizing. Requires prior authorization.
D9999	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. Requires prior authorization.

~~*(3-15-02)*~~(7-1-03)T

912. PREGNANT WOMEN AND CHILDREN (PWC) CODES.
The following are the only codes covered for women on the Pregnant Women and Children (PWC) program.

TABLE 912 - PREGNANT WOMEN AND CHILDREN (PWC) CODES	
Dental Code	**Description**
01. Clinical Oral Examinations.	
D0140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem.
02. Radiographs.	
D0220	Intraoral - periapical - first film.
D0230	Intraoral - periapical - each additional film.
D0330	Panoramic film.
03. Restorative Services.	
D2940	Sedative filling. Tooth designation required.
04. Pulp Capping.	
~~*D3110*~~	~~*Pulp cap - direct (excluding final restoration). Tooth designation required.*~~
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required.
05. Adjunctive Periodontal Services.	
D~~0~~4341	Periodontal scaling, root plan~~n~~ing, four (4) or more contiguous teeth per quadrant. Allowed once in a twelve-month period. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant. Allowed once in a twelve-month period. This procedure is indicated for clients with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.
06. Oral Surgery. Extractions - includes local anesthesia and routine postoperative care.	
~~*D7110*~~	~~*Single tooth. Tooth designation required.*~~

TABLE 912 - PREGNANT WOMEN AND CHILDREN (PWC) CODES	
Dental Code	**Description**
D7111	Extraction, coronal remnants - deciuous tooth. Including soft-tissue retained coronal remnants.
~~*D7120*~~	~~*Each additional tooth. Tooth designation required.*~~
~~*D7130*~~	~~*Root removal - exposed roots. Tooth designation required.*~~
D7140	Extraction, erupted tooth or exposed root, routine removal.
07. Surgical. Extractions - includes local anesthesia and routine postoperative care.	
D7210	Surgical removal of an erupted tooth requiring elevation of the mucoperiosteal flap and removal of tooth structure, and closure. Tooth designation required.
D7220	Removal of impacted tooth - soft tissue. Tooth designation required.
D7230	Removal of impacted tooth - partially bony. Tooth designation required.
~~*D7240*~~	~~*Removal of impacted tooth - completely bony. Tooth designation required.*~~
~~*D7241*~~	~~*Removal of impacted tooth - complicated. Tooth designation required.*~~
D7250	Surgical removal of residual tooth roots (cutting procedure). Tooth designation required.
08. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
09. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedures.
10. Professional Consultation.	
D9310	Consultation. Provided by dentist or physician whose opinion or advice regarding the evaluation, management and/or treatment of a specific problem or condition is requested by another dentist or physician. The written or verbal request for a consult must be documented in the client's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the client's medical record and communicated to the requesting dentist or physician. A dental consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
11. Professional Visits.	
D9420	Hospital Call. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited to once per day per client.
~~*D9430*~~	~~*Office visit for observation - regular office hours - no other services performed.*~~
D9440	Office visit - after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

~~*(3-15-02)*~~(7-1-03)T

913. DENTURIST POLICY GUIDELINES.

01. Overview. Idaho Medicaid processes charges submitted by Idaho licensed denturists for services provided to eligible clients. Approved services are limited to those services allowed by Idaho code for Idaho licensed denturists. (3-15-02)

02. Client Eligibility. ~~*Clients without eligibility restrictions are eligible for denturist services.*~~ Clients eligible for the Pregnant Women and Children (PWC) program or who have only QMB eligibility are not eligible for denturist services. ~~*(3-15-02)*~~(7-1-03)T

03. Prior Authorization. Prior authorization is not required for the denturist procedures except for dental code 0515D found in Section 8~~*39*~~14 of these rules. ~~*Eligibility must be checked with VRS.*~~ ~~*(3-15-02)*~~(7-1-03)T

04. Payment. Denturists will be reimbursed for procedures on a fee-for-service basis. Usual and customary charges will be paid up to the Medicaid maximum allowance. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the client cannot be billed for the difference between the billed amount and the Medicaid allowed amount. ~~*(3-15-02)*~~(7-1-03)T

05. Service Limitations. Medicaid allows complete and immediate denture construction once every five (5) years. Denture reline is allowed once every two (2) years. Complete and partial denture adjustment is considered part of the initial denture construction service for the first six (6) months. (3-15-02)

914. DENTURIST PROCEDURE CODES.
The following codes are valid denturist procedure codes:

TABLE 8~~*39*~~14 - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
0515D	Unable to deliver full denture. ~~*Arch designation required.*~~ Prior authorization required. ~~*Laboratory cost may be paid for full dentures i*~~If the client~~*: a) decides*~~ does not ~~*to*~~ complete the process for the denture; ~~*b)*~~ leaves the state; ~~*c)*~~ cannot be located; ~~*d) expires*~~ or dies; laboratory and professional fees may be billed to Medicaid with an invoice listing lab fees and arch designation.
5110D	Complete denture, upper
5120D	Complete denture, lower
5130D	Immediate denture, upper
5140D	Immediate denture, lower
5410D	Adjust complete denture, upper
5411D	Adjust complete denture, lower
5421D	Adjust partial denture, upper
5422D	Adjust partial denture, lower
5510D	Repair broken complete denture base; arch designation required.
5520D	Replace missing or broken teeth, complete denture (each tooth); six (6) teeth maximum. Tooth designation required.
5610D	Repair resin saddle or base; arch designation required.
5620D	Repair cast framework; arch designation required.
5630D	Repair or replace broken clasp; arch designation required.
5640D	Replace broken teeth per tooth; tooth designation required.
5650D	Add tooth to existing partial denture; tooth designation required.
5660D	Add clasp to existing partial denture; not requiring the altering of oral tissue or natural teeth. Tooth designation required.

TABLE 8~~39~~14 - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
5730D	Reline complete upper denture (chairside)
5731D	Reline complete lower denture (chairside)
5740D	Reline upper partial denture (chairside)
5741D	Reline lower partial denture (chairside)
5750D	Reline complete upper denture (laboratory)
5751D	Reline complete lower denture (laboratory)
5760D	Reline upper partial denture (laboratory)
5761D	Reline lower partial denture (laboratory)

~~*(3-15-02)*~~(7-1-03)T

915. DENTAL CODES FOR ADULT SERVICES.
The following dental codes are covered for adults after the month of their twenty-first birthday.

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
01. Dental Diagnostic Procedures. The definitions for these codes are in Section 901 of theses rules.	
a. General Oral Evaluations.	
D0120	Periodic oral evaluation.
D0140	Limited oral evaluation.
D0150	Comprehensive oral evaluation.
b. Radiographs/Diagnostic Images.	
D0210	Intraoral - complete series.
D0220	Intraoral periapical - first film.
D0230	Intraoral periapical - each additional film.
D0270	Bitewing - single film.
D0272	Bitewings - two (2) films.
D0274	Bitewings - four (4) films.
D0277	Vertical bitewings - seven (7) to eight (8) films.
D0330	Panoramic film.
02. Dental Preventive Procedures. The definitions for these codes are in Section 902 of these rules.	
a. Dental Prophylaxis.	
D1110	Prophylaxis - adult.
b. Fluoride Treatments.	

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D1204	Topical application of fluoride - prophylaxis not included - adult.
03. Dental Restorative Procedures. The definitions for these codes are in Section 903.05 of these rules.	
a. Amalgam Restorations.	
D2140	Amalgam - one (1) surface, primary or permanent.
D2150	Amalgam - two (2) surfaces, primary or permanent.
D2160	Amalgam - three (3) surfaces, primary or permanent.
D2161	Amalgam - four (4) or more surfaces, primary or permanent.
b. Resin Restorations.	
D2330	Resin - one (1) surface, anterior.
D2331	Resin - two (2) surfaces, anterior.
D2332	Resin - three (3) surfaces, anterior.
D2335	Resin - four (4) or more surfaces or involving incisal angle, anterior.
D2390	Resin based composite crown, anterior, primary or permanent.
D2391	Resin based composite - one (1) surface, posterior, primary or permanent.
D2392	Resin based composite - two (2) surfaces, posterior, primary or permanent.
D2393	Resin based composite - three (3) surfaces, posterior, primary or permanent.
D2394	Resin based composite - four (4) surfaces, posterior, primary or permanent.
c. Other Restorative Services.	
D2920	Re-cement crown. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth.
D2940	Sedative filling.
04. Endodontics. The definitions for these codes are in Section 904 of these rules.	
D3220	Therapeutic pulpotomy.
D3221	Pulpal debridement, permanent teeth.
05. Periodontics. The definitions for these codes are in Section 905 of these rules.	
a. Non-Surgical Periodontal Service.	
D4341	Periodontal scaling and root planing - four (4) or more contiguous teeth (per quadrant).
D4342	Periodontal scaling and root planing one (1) to three (3) teeth per quadrant.
D4355	Full mouth debridement.
b. Other Periodontal Services.	
D4910	Periodontal maintenance procedures.

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
06. Prosthodontics. The definitions for these codes are in Section 906 of these rules.	
a. Complete Dentures.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
b. Partial Dentures.	
D5211	Maxillary partial denture - resin base.
D5212	Mandibular partial denture - resin base.
c. Adjustments to Dentures.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
d. Repairs to Complete Dentures.	
D5510	Repair broken complete denture base.
D5520	Replace missing or broken teeth - complete denture, each tooth.
e. Repairs to Partial Dentures.	
D5610	Repair resin denture base.
D5620	Repair cast framework.
D5630	Repair or replace broken clasp.
D5640	Replace broken teeth, per tooth.
D5650	Add tooth to existing partial denture.
D5660	Add clasp to existing partial denture.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
f. Denture Relining.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline maxillary partial denture (chairside).
D5741	Reline mandibular partial denture (chairside).
D5750	Reline complete maxillary denture (laboratory).

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
07. Oral Surgery. The definitions for these codes are in Section 909 of these rules.	
a. Extractions.	
D7111	Extraction, coronal remnants - deciduous tooth.
D7140	Extraction, erupted tooth or exposed root, routine removal.
b. Surgical Extractions	
D7210	Surgical removal of erupted tooth.
D7220	Removal of impacted tooth - soft tissue.
D7230	Removal of impacted tooth -- partially bony.
D7240	Removal of impacted tooth - completely bony.
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250	Surgical removal of residual tooth roots.
c. Other Surgical Procedures.	
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
d. Surgical Incision.	
D7510	Incision and drainage of abscess - including periodontal origins.
e. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
f. Other Repair Procedures.	
D7970	Excision of hyperplastic tissue.
D7971	Excision of pericoronal gingiva.
08. Adjunctive General Services. The definitions for these codes are in Section 911 of these rules.	
a. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain.
b. Anesthesia.	
D9220	Deep sedation/general anesthesia - first thirty (30) minutes.
D9221	Deep sedation/general anesthesia - each additional fifteen (15) minutes.
D9230	Analgesia - includes nitrous oxide.
D9241	Intravenous conscious sedation/analgesia - first thirty (30) minutes.
D9242	Intravenous conscious sedation/analgesia - each additional fifteen (15) minutes.

TABLE 915 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
c. Professional Consultation.	
D9310	Consultation requested by other dentist or physician.
d. Professional Visits.	
D9410	House, institutional, or extended care facility calls.house/extended care facility.
D9420	Hospital calls.
D9440	Office visit after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

(7-1-03)T

09. Clients Eligible For Other Programs. Clients who are eligible for the Pregnant Women and Children (PWC) program or have only Qualified Medicare Beneficiary (QMB) eligibility are not covered under this section of rule. (7-1-03)T

915~~5~~6. DENTAL PRIOR AUTHORIZATION.
All procedures that require prior authorization must be approved by the Medicaid dental consultant prior to the service being rendered. Prior authorization requires written submission including diagnostics. Verbal authorizations will not be given. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility. Prior authorization of Medicaid dental procedures does not guarantee payment. Client Medicaid eligibility must be verified by the provider before the authorized service is rendered. (3-15-02)

916~~7~~. -- 995. (RESERVED).

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0305

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the August 6, 2003 Idaho Administrative Bulletin, Volume 03-8, pages 92 through 94.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Christine Baylis at (208) 364-1891.

DATED this 9th day of October, 2003.

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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING MEDICAL ASSISTANCE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-8, August 6, 2003, pages 92 through 94.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0305

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 20, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Section 506 is being amended to delete a level of care scoring system on supervision that is not consistent with the Uniform Assessment Instrument that is currently being used. These changes will reflect current practices and assure services identified on the UAI are appropriate to the individual's need.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. Public comment should be addressed to these additions and deletions.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes follow the Uniform Assessment Instrument which is the standard assessment being used.

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

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before August 27, 2003.

DATED this 23rd day of June, 2003.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0305

506. CRITERIA FOR DETERMINING NEED FOR NF CARE.
The recipient requires NF level of care when an adult meets or exceeds the functional level described in Subsection 506.06, or when a child meets one (1) or more of the criteria described in Subsections 506.07, 506.08, 506.09 or 506.10. A child is an individual from age zero (0) through eighteen (18) years; an adult is an individual more than eighteen (18) years. (3-15-02)

01. Required Assessment, Adults. A standard assessment will be administered by the Department or its designee to all adults requesting services with requirements for Nursing Facility (NF) level of care. The Department will specify the instrument to be used. (3-30-01)

02. Functional Level, Adults. Based on the results of the assessment, the level of impairment of the individual will be established by the Department or its designee. In determining need for NF care an adult must require the level of assistance listed in Subsections 506.03 through 506.05, according to the formula described in Subsection 506.06: (3-15-02)

03. Critical Indicator (Twelve (12) Points Each). (3-30-01)

a. Total assistance with preparing or eating meals. (3-15-02)

b. Total or extensive assistance in toileting. (3-30-01)

c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. (3-30-01)

04. High Indicator (Six (6) Points Each). (3-30-01)

a. Extensive assistance with preparing or eating meals. (3-15-02)

b. Total or extensive assistance with routine medications. (3-30-01)

c. Total, extensive or moderate assistance with transferring. (3-30-01)

d. Total or extensive assistance with mobility. (3-30-01)

e. Total or extensive assistance with personal hygiene. (3-30-01)

f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). (3-30-01)

05. Medium Indicator (Three (3) points each). (3-30-01)

a. Moderate assistance with personal hygiene. (3-30-01)

b. Moderate assistance with preparing or eating meals. (3-15-02)

c. Moderate assistance with mobility. (3-30-01)

d. Moderate assistance with medications. (3-30-01)

e. Moderate assistance with toileting. (3-30-01)

f. Total, extensive, or moderate assistance with dressing. (3-30-01)

g. Total, extensive or moderate assistance with bathing. (3-30-01)

h. ~~*Frequent or continuous supervision in one (1) or more of the following cognitive areas from Section IV of the UAI:*~~ Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. ~~*(3-30-01)*~~(7-1-03)T

~~*i.* *Orientation;* *(3-30-01)*~~

~~*ii.* *Memory;* *(3-30-01)*~~

~~*iii.* *Judgement;* *(3-30-01)*~~

~~*iv.* *Wandering;* *(3-30-01)*~~

~~*v.* *Disruptive/socially inappropriate behavior;* *(3-30-01)*~~

~~*vi.* *Assaultive/destructive behavior;* *(3-30-01)*~~

~~*vii.* *Self preservation; or* *(3-30-01)*~~

~~*viii.* *Danger to self.* *(3-30-01)*~~

06. NF Level Of Care, Adults. In order to qualify for NF level of care, the individual must score twelve (12) or more points in one (1) of the following ways. (3-15-02)

a. One (1) or more critical indicators = Twelve (12) points (3-30-01)

b. Two (2) or more high indicators = Twelve (12) points (3-30-01)

c. One (1) high and two (2) medium indicators = Twelve (12) points (3-30-01)

d. Four (4) or more medium indicators = Twelve (12) points (3-30-01)

07. Supervision Required, Children. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. (3-30-01)

08. Preventing Deterioration, Children. Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. (3-30-01)

09. Specific Needs, Children. When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. (3-30-01)

10. NF Level Of Care, Children. Using the criteria found in Subsections 506.07, 506.08, and 506.09, plus consideration of the developmental milestones, based on the age of the child, the Department's RMU will determine NF level of care. (3-30-01)

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0306

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), and 56-1004(l)(a), Idaho Code.

DESCRIPTIVE SUMMARY: The pending rules are being adopted as proposed. The original text of the proposed rules was published in the September 3, 2003, Administrative Bulletin, Volume 03-9, pages 103 through 105.

The following is a non-technical explanation of the substance and purpose of the rulemaking: As a part of the Medicaid budget appropriation for State Fiscal year (SFY) 2004, the Department was given $147,900 with which to provide additional Targeted Case Management for the mentally ill. However, this appropriation was made subsequent to implementation of budget holdbacks during State Fiscal Year (SFY) 2003. Because the appropriation does not restore funding to prior levels, this proposed rule reduces coverage for crisis case management (from four (4) to three (3) hours) while increasing the coverage for non-crisis case management (from four (4) to five (5) hours). The Department believes greater commitment to non-crisis care can reduce the need for crisis care.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Paul Leary or Pat Guidry at (208) 364-1840.

DATED this 27th day of October, 2003.

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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-9, September 3, 2003, pages 103 through 105.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0306

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), and 56-1004(l)(a), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 17, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

As a part of the Medicaid budget appropriation for State Fiscal Year (SFY) 2004, the Department was given an additional $147,900 with which to provide additional Targeted Case Management for the mentally ill. In order to respond to the appropriation, crisis case management hours are reduced from four (4) to three (3) hours and ongoing non-crisis case management hours are increased from four (4) to five (5) hours.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to confer a benefit.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because rulemaking occurred to comply with legislative action.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Paul Leary or Pat Guidry at (208) 364-1833

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before September 24, 2003.

DATED this 23rd day of July, 2003.

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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0306

483. PAYMENT FOR SERVICES.
When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as CM services, however, the actual provision of the service does not constitute CM. Medicaid will reimburse only for core services (Section 480 of these rules) provided to members of the eligible target group by qualified staff. (12-1-02)T

01. Duplication. Payment for CM will not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-30-01)

02. Inpatients. Payment will not be made for CM services provided to individuals who are inpatients in nursing homes or hospitals. (3-30-01)

03. Evaluation/Service Plan Development. Reimbursement for the initial evaluation and individual service plan development shall be paid based on an hourly rate, not to exceed six (6) hours. The rate will be established by the Department. (12-1-02)T

04. Case Management. Reimbursement for on-going case management services shall be at a rate established by the Department. (12-1-02)T

05. Reimbursement. Medicaid reimbursement shall be provided only for the following case management services: (3-30-01)

a. Face-to-face contact between the case manager and the recipient, no less than every thirty days; (3-30-01)

b. Telephone contact between the case manager and the recipient, the recipient's mental health and other service providers, a recipient's family members, primary caregivers, legal representative, or other interested persons; (8-1-92)

c. Face-to-face contacts between the case manager and the recipient's family members, legal representative, primary caregivers, mental health providers or other service providers, or other interested persons; (8-1-92)

d. Development, review, and revision of the recipient's individual service plan, including the case manager's functional assessment of the recipient. (8-1-92)

06. Services Delivered Prior To Assessment. The Department will not provide Medicaid reimbursement for on-going non-crisis case management services delivered prior to the completion of the assessments and individual service plan. (4-28-03)T

07. Crisis Case Management. The Department will provide Medicaid reimbursement for crisis case management services identified under Subsection 478.03 of these rules. Crisis case management services may be delivered prior to, or after, the completion of the assessment and individual service plan. Without authorization by the Department or its designee, crisis case management services are limited to a total of ~~*four*~~ three (~~*4*~~3) hours per calendar month. The Department or its designee may authorize additional crisis case management services beyond the ~~*four*~~ three (~~*4*~~3) hour limit if a recipient still has severe or prolonged crisis case management needs that meet all of the following criteria: ~~*(4-28-03)T*~~(7-1-03)T

a. The service recipient is at imminent risk (within fourteen (14) days) of hospitalization or institutionalization, including jail or nursing home; and (4-28-03)T

b. The service recipient is experiencing symptoms of psychiatric decompensation; and (4-28-03)T

c. The service recipient has already received the maximum number of monthly hours of ongoing case management and crisis case management services; and (4-28-03)T

d. No other crisis assistance services are available to the recipient under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR). (4-28-03)T

08. **Audit Reviews**. Audit reviews will be conducted at least once a calendar year by the Department or its designee. Review findings may be referred to the Department's Surveillance and Utilization Review Section for appropriate action. (12-1-02)T

09. **Recoupment**. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (3-30-01)

10. **Information**. The provider will provide the Department with access to all information required to review compliance with these rules. (3-30-01)

11. **Group Case Management**. The Department will not provide Medicaid reimbursement for case management services provided to a group of recipients. (3-30-01)

12. **Case Management In A Facility**. Medicaid will reimburse for case management services on the same date a recipient is admitted or discharged from a hospital, nursing facility, or other institutional setting, as long as the recipient is not yet admitted or has been discharged at the time of service delivery. Services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those included in the responsibilities of the facility. (3-30-01)

13. **On-Going Non-Crisis Case Management**. On-going non-crisis case management services are limited to a total of ~~*four*~~ five (~~*4*~~5) hours per calendar month. ~~*(4-28-03)T*~~(7-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0307

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective date of the amendments to the temporary rule is October 1, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), and 56-1004(l)(a), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

In response to comments received in the hearings held in October, and comments received from the public and Department staff, minor changes have been made for clarification.

Pursuant to Section 67-5228, Idaho Code, typographical, transcriptional, and/or clerical corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the September 3, 2003, Administrative Bulletin, Volume 03-9, pages 106 through 125.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mary Wells at (208) 364-1840 or Jean Christensen at (208) 364-1973.

DATED this 19th day of November, 2003.

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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-9, September 3, 2003, pages 106 through 125.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0309-0307

SUBSECTIONS 11804.h. and 118.05 (Partial Section)

118. TARGETED DEVELOPMENTAL DISABILITIES SERVICE COORDINATION.
The Department will purchase targeted case management, hereafter referred to as Targeted Service Coordination (TSC) for Medicaid-eligible participants with developmental disabilities when authorized through the Department's prior authorization process in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services," and provided by an organized service coordination provider agency who has entered into a written provider agreement with the Department. The purpose of these services is to assist eligible individuals to obtain needed health, educational, vocational, residential, and social services. (10-1-03)T

04. TSC Provider Staff Qualifications. All individual service coordinators, paid plan developers, and paid plan monitors must be employees or contractors of an organized provider agency that has a valid provider agreement with the Department. The employing entity will supervise the individual service coordinators, paid plan developers, and paid plan monitors and assure that they meet the following qualifications: (10-1-03)T

h. Paraprofessionals may be used to assist in the implementation of the plan of service. They may not be paid plan developers or plan monitors. Paraprofessionals must meet the following qualifications: (10-1-03)T

i. Be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); (10-1-03)T

ii. Be able to read and write at a level commensurate with the general flow of paperwork and forms; and (10-1-03)T

iii. Complete a training program developed by the Department and be working under the supervision of a fully qualified targeted service coordinator. (10-1-03)T

iv. All paraprofessionals must satisfactorily complete the Department's criminal history check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". (10-1-03)T

05. Participant's Choice. The participant may choose to receive or not to receive TSC services. The participant has the choice of: (10-1-03)T

a. Developing and monitoring his own plan of service, with the choice of still using the services ~~*coordination*~~ described in Subsection 118.02.a. of these rules; or ~~*(10-1-03)T*~~(10-1-03)T

b. Using the targeted service coordinator for plan development, monitoring, and service coordination; or (10-1-03)T

c. Selecting a non-paid plan developer, and receiving plan monitoring and service coordination by a targeted service coordinator~~.~~; or ~~*(10-1-03)T*~~(10-1-03)T

d. Selecting a non-paid plan developer and a non-paid plan monitor and not receiving service coordination. (10-1-03)T

SECTION 120, SUBSECTIONS 120.04 and 120.04.c. through 120.04.g. (Partial Section)

120. REHABILITATIVE SERVICES -- DEVELOPMENTAL DISABILITIES AGENCIES.
Under 42 CFR 440.130(d), the Department will pay for rehabilitative services including medical or remedial services provided by facilities that have entered into a provider agreement with the Department and are licensed as developmental disabilities agencies by the Department. Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. ~~*(10-1-03)T*~~(10-1-03)T

04. ~~***Treatment***~~ **Therapy Services**. Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies". The therapy services listed in Subsections 120.04.a. through 120.04.f. of this rule may be prior authorized for up to thirty (30) hours per week. These ~~*treatment*~~ therapy services ~~*listed below in Subsections 120.04.a. through 120.04.c. of this rule and*~~ in combination with community supported employment services must not be authorized for more than forty (40) hours per week. Covered treatment services include the following therapies: ~~*(10-1-03)T*~~(10-1-03)T

c. Speech and Hearing Therapy Services. Speech and hearing therapy services are limited to two hundred fifty (250) treatment sessions per calendar year. Speech and hearing therapy includes individual or group therapy. ~~*(10-1-03)T*~~(10-1-03)T

d. Physical Therapy. Physical therapy services are limited in accordance with Section 140 of these rules. Physical therapy includes individual or group therapy. ~~*(10-1-03)T*~~(10-1-03)T

e. Occupational Therapy. Occupational therapy includes individual occupational therapy and group occupational therapy. Developmental and occupational therapy services alone or in combination are limited to a maximum of thirty (30) hours per week. ~~*(10-1-03)T*~~(10-1-03)T

f. Intensive Behavioral Intervention (IBI). Intensive behavioral intervention includes individual intensive behavioral intervention and intensive behavioral intervention consultation. (10-1-03)T

g. Collateral Contact. Collateral contact ~~*is contact with individuals directly involved with the participant receiving the service to promote understanding of each person's therapeutic objectives and consistency among persons having direct contact with the program participant. Such contacts will be included in the limitations*~~

~~*of hours of treatment service reimbursed by Medicaid. Contacts with such persons for the purpose of future placement, interagency and intra-agency case monitoring, staffings and social service activities are not allowable for Medicaid payment.*~~ is consultation or treatment direction about the participant to a significant other in the participant's life and may be conducted face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursable. ~~*(10-1-03)T*~~(10-1-03)T

SUBSECTIONS 143.05.a.i.(4) and 143.05.l.iv. (Partial Section)

143. WAIVER SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES AND ISSH WAIVER PARTICIPANTS.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/MR. (10-1-03)T

05. Provider Qualifications. All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (10-1-03)T

a. Residential habilitation services must be provided by an agency that is certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and is capable of supervising the direct services provided. Individuals who provide twenty-four (24) hour services in their own home must be certified by the Department as a certified family home and must be affiliated with a Residential Habilitation Agency. The Residential Habilitation Agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (10-1-03)T

i. Direct service staff must meet the following minimum qualifications: (10-1-03)T

(4) ~~*Pass*~~ Satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". When residential habilitation services are provided in a certified family home, all ~~*adults*~~ individuals eighteen (18) years of age or older living in the home must ~~*pass*~~ satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06; ~~*(10-1-03)T*~~(10-1-03)T

l. Providers of adult day care services must be employed by or be affiliated with the residential habilitation agency that provides program coordination for the participant if the service is provided to a single participant in a certified family home other that the participant's primary residence, be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: (10-1-03)T

iv. ~~*Pass*~~ Satisfactorily complete a criminal history check ~~*as required by*~~ in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"; ~~*(10-1-03)T*~~(10-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0307

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective July 15, 2003 and October 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), and 39-4601, Idaho Code.

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

Monday, October 6, 2003	**Wednesday, October 8, 2003**	**Thursday, October 9, 2003**
7:00 - 9:00 p.m.	**7:00 - 9:00 p.m.**	**7:00 - 9:00 p.m.**
Region I	**Region IV**	**Region VI**
1120 Ironwood Drive	**1720 Westgate Drive**	**421 Memorial Drive**
Coeur d'Alene, ID	**Boise, ID**	**Pocatello, ID**

The hearing sites 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 non-technical explanation of the substance and purpose of the proposed rule making:

These rule changes are being made to support the implementation of the Department's new prior authorization process found in new chapter of rules, IDAPA 16.03.13, "Prior Authorization of Behavioral Health Services". In those portions of the text dealing with the prior authorization process, citations have been inserted to refer the reader to IDAPA 16.03.13. Other changes have been made to align terminology and content with that in IDAPA 16.03.13.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. Public comment should be addressed to these additions and deletions.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226(1)(a), Idaho Code and are necessary in order to protect the public health, safety and welfare.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted by the Department of Health and Welfare. However, during the past three (3) years, the Department has engaged both in extensive public participation efforts and a pilot program to gather public input on and subsequently develop and test the prior authorization process formalized in this rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Mary Wells at (208) 364-1955.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 22, 2003.

DATED this 30th day of July, 2003.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0307

118. TARGETED DEVELOPMENTAL DISABILITIES SERVICE COORDINATION.
The Department will purchase targeted case management, hereafter referred to as Targeted Service Coordination (TSC) for ~~*adult*~~ Medicaid-eligible ~~*recipients*~~ participants with developmental disabilities when authorized ~~*by the Regional ACCESS Unit*~~ through the Department's prior authorization process in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services," and provided by an organized service coordination provider agency who has entered into a written provider agreement~~*/contract*~~ with the Department. ~~*The Department will only provide Targeted Service Coordination in a geographic area where such service is not available through a private provider who has entered into a provider agreement/contract with the Department.*~~ The purpose of these services is to assist eligible individuals to obtain needed health, educational, vocational, residential, and social services.
~~*(3-16-95)*~~(10-1-03)T

01. Eligible Target Group. Only Medicaid eligible adults, eighteen (18) years of age or older, and adolescents, age fifteen (15) through the month of their eighteenth birthday, who are eligible for the Idaho State School and Hospital (ISSH) waiver who desire to live, learn, or work in community based settings are eligible. All participants must have a ~~*primary*~~ diagnosis of ~~*D*~~developmental ~~*D*~~disability. ~~*(3-30-01)*~~(7-15-03)T

a. The following diagnostic and functional criteria will be applied to determine ~~*membership in the target population*~~ eligibility for Targeted Service Coordination: "Developmental Disability," as defined in Section 66-402, Idaho Code, means a chronic disability of a person that appears before twenty-two (22) years of age and:
~~*(1-7-94)*~~(10-1-03)T

~~*i. "Developmental Disability" means a chronic disability of a person which appears before the age of twenty-two (22) years of age and:*~~ ~~*(10-1-94)*~~

~~*(1)*~~i. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and (10-1-94)

~~*(2)*~~ii. Results i~~s~~n substantial functional limitations in three (3) or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and ~~*(10-1-94)*~~(10-1-03)T

~~*(3)*~~iii. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned or coordinated.
(10-1-94)

b. Eligible individuals may reside in certified family homes, residential care, semi-independent living, room and board, their own homes, or be homeless. (12-1-02)T

c. Eligible individuals may be receiving ~~*habilitation, supportive assistance, respite*~~ DDA services, waiver services, or other services. These individuals may not be receiving any other types of service coordination.
~~*(1-7-94)*~~(10-1-03)T

02. TSC Service Description. ~~*TSC shall be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational, residential, and social services using the least restrictive and most appropriate procedures and settings.*~~ Targeted service coordinators may be paid plan developers and plan monitors as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". TSC ~~*shall*~~ consists of the following core functions: ~~*(10-1-94)*~~(10-1-03)T

a. ~~*Individual Assessment and Service Planning. Unless specifically excluded by the recipient, an Individual Support Plan (ISP) shall be developed in conjunction with the recipient, service providers, the recipient's family and/or guardian and other individuals selected by the recipient.*~~ Linking the Participant to Needed Services.

Linking includes finding, arranging, and assisting the participant with maintaining the services, supports, and community resources identified on the plan of service. Linking also includes advocating for the unmet needs of the participant and encouraging his independence. ~~*(3-16-95)*~~(10-1-03)T

~~*i. The ISP shall replace existing service plans, except when such plans are required by other rules, and be developed from a person-centered planning process and include information obtained from evaluations (assessments), consumer interview, observation in community settings, and other pertinent information. (10-1-94)*~~

~~*ii. The plan shall be directed at meeting the individual recipient's needs, primarily by building on, maintaining, and utilizing the recipient's identified strengths and abilities. Services proposed must: be the result of on-going planning; be built around the recipient's wants and needs; encourage the recipient to choose the locality in which he lives and works; be age appropriate; include, whenever possible, two (2) or more options from which the recipient may choose; be aimed at maximizing community participation; be culturally appropriate; be designed to promote and utilize natural and informal community supports, including family, friends, and other non-paid citizens; and be designed with supports and services necessary to succeed in his chosen environment. (1-7-94)*~~

~~*iii. The plan must be completed within ninety (90) days of the selection of the service coordinator, unless documentation of a delay based on consumer need is submitted to the regional ACCESS unit. (5-24-95)*~~

~~*iv. The plan must be written in language that is easily understood by the consumer and his team. (5-24-95)*~~

b. ~~*The service coordinator is responsible for writing the plan, and submitting it to the Regional ACCESS Unit for authorization of Medicaid and state general fund eligibility. The service coordinator will be responsible for finding alternative funding/resources for services and supports not deemed eligible for Medicaid or state general fund reimbursement.*~~ Monitoring and Coordination of Services. Monitoring and coordination of services includes assisting the participant and his family or guardian to coordinate and retain services and assure consistency and nonduplication between services. This includes assuring that the services are satisfactory to the participant and making adjustments to the plan of service when needed. Targeted service coordinators must report immediately all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the Regional Medicaid Services (RMS), the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. ~~*(10-1-94)*~~(10-1-03)T

~~***c.*** *Implementation. The service coordinator shall arrange for services necessary to execute the ISP. (10-1-94)*~~

~~***d.*** *Monitoring. The service coordinator shall review, update and monitor the plan continuously to meet the recipient's changing needs. This can occur through phone contact and/or face-face meetings with the participant. Monitoring includes discussing changes, assessing satisfaction with services, evaluating progress and making necessary changes based on the service coordinator's evaluation. (12-1-02)T*~~

~~***e.*** *Enablement. The service coordinator shall enable the recipient whenever possible. Enablement includes but is not limited to the following: (10-1-94)*~~

~~*i. Providing information in ways that empower the recipient to make an informed decision; (1-7-94)*~~

~~*ii. Assuring that all placements in the service delivery system shall be to services which offer the individual the best available opportunity for personal development, provide an improved quality of life, and are within the least restrictive environment appropriate to the individual. (1-7-94)*~~

~~*iii. Ensure that all residential arrangements are community-based. Such arrangements may include, but are not limited to, the recipient's family's residence, or an independent living arrangement. (1-7-94)*~~

~~*iv. Ensure that providers comply with clients' rights as specified in the Developmental Disabilities Act. (10-1-94)*~~

~~*v. Assure that no one shall be denied TSC solely on the basis of the severity of physical or mental*~~

~~*disability.*~~ ~~*(12-1-02)T*~~

~~*vi. If the placement or services which are recommended are not immediately available, continued attempts to try to access the service or placement for the recipient must be documented.* (1-7-94)~~

~~*vii. The service coordinator will foster the independence of the recipient (family or guardian if appropriate) by demonstrating to the individual how best to access service delivery systems.* (10-1-94)~~

03. Targeted Service Coordination Agency Qualifications. Targeted Service Coordination agencies must meet the following criteria: (10-1-94)

a. Have ~~D~~demonstrated the ability to provide supervision over and assure the provision of all the core ~~*elements listed*~~ functions of Targeted Service Coordination to the target population as described in Subsection 11~~9~~8.02 of ~~*TSC to the target population; and*~~ these rules ~~*(10-1-94)*~~(10-1-03)T

b. ~~*May contract with individual service coordinators or case management agencies to provide TSC services.*~~ Employ individuals qualified to do Targeted Service Coordination; ~~*(10-1-94)*~~(10-1-03)T

c. Not provide service coordination to any individual for whom the agency, owners or employees also provide direct services. Agencies must disclose any interest by the owners of the agency, ~~*or*~~ their employees~~/~~ or their contractors in any other agency that provides services to people with developmental disabilities~~.~~; ~~*(10-1-94)*~~(10-1-03)T

d. ~~*The individual or agency employees*~~ Assure that all targeted service coordinators they employ successfully complete the service coordination certification ~~*training*~~ specified by the Department; ~~*(10-1-94)*~~(10-1-03)T

e. ~~*The individual or agency f*~~Follow~~s~~ the written procedures for service coordination authorized and adhered to by the Department; ~~*(10-1-94)*~~(10-1-03)T

f. Adhere~~s~~ to the Department's mission and value statements for "right service," "right setting," and "right cost"; and ~~*(10-1-94)*~~(10-1-03)T

g. Adhere~~s~~ to the Department's ~~*contract*~~ requirements, billing, and reimbursement procedures. ~~*(10-1-94)*~~(10-1-03)T

04. TSC Provider Staff Qualifications. All individual service coordinators, paid plan developers, and paid plan monitors must be employees or contractors of an organized provider agency that has a valid provider agreement~~*/contract*~~ with the Department. The employing entity will supervise the individual service coordinators, paid plan developers, and paid plan monitors and assure that they meet the following qualifications~~*are met for each individual service coordinator*~~: ~~*(10-1-94)*~~(10-1-03)T

a. Must be a psychologist, Ph.D., Ed.D., M.A./M.S.; nurse, B.S.N., M.S., Ph.D.; Q.M.R.P.; Developmental Specialist; M.D.; D.O.; or possess a valid Idaho social work license issued by the Board of Social Work Examiners; ~~*and*~~ ~~*(10-1-94)*~~(10-1-03)T

b. Must have documentation of at least twelve (12) months~~*, at*~~ based on an average of twenty (20) hours per week, of on-the-job experience providing direct service to the target population, or be working under the supervision of a fully qualified service coordinator; ~~*and*~~ ~~*(12-1-02)T*~~(10-1-03)T

c. ~~*A*~~ Must satisfactorily complete a criminal history check ~~*with finger printing shall be obtained*~~ as required by IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"; ~~*and*~~ ~~*(10-1-94)*~~(10-1-03)T

d. Must be supervised by an individual with the authority to oversee the service delivery, and to remove the individual if the ~~*recipient's*~~ participant's needs are not met; provider agencies will supervise their service coordinators, plan developers, and plan monitors; ~~*and*~~ ~~*(10-1-94)*~~(10-1-03)T

e. Cannot be the service coordinator, plan developer, or plan monitor for any ~~*recipient*~~ participant for whom the service coordinator has individual responsibility for the provision of any other care or treatment; ~~*and*~~ ~~*(10-1-94)*~~(10-1-03)T

f. Must have at least six (6) months work experience both as an EPSDT service coordinator, as described in Section 530 of these rules, and as a targeted service coordinator if they are providing services for adolescents on the ISSH waiver; (10-1-03)T

~~*f*~~**g.** ~~*At no time will the*~~ Must not at any time have a total caseload ~~*of a service coordinator be*~~ so large as to violate the purpose of the program or adversely affect the health and welfare of any ~~*recipient*~~ participant served by the service coordinator. ~~*(12-1-02)T*~~(10-1-03)T

~~*g*~~**h.** Paraprofessionals may be used to assist in the implementation of the ~~*ISP*~~ plan of service. They may not be paid plan developers or plan monitors. Paraprofessionals must meet the following qualifications: ~~*(10-1-94)*~~(10-1-03)T

i. ~~*Must b*~~Be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); ~~*and (1-7-94)*~~(10-1-03)T

ii. ~~*Must b*~~Be able to read and write at a level commensurate with the general flow of paperwork and forms; and ~~*(1-7-94)*~~(10-1-03)T

iii. ~~*Must c*~~Complete a training program developed by the ~~*Division of Family and Community Services*~~ Department and be working under the supervision of a fully qualified targeted service coordinat~~*ion*~~or.~~*; and*~~ ~~*(10-1-94)*~~(10-1-03)T

~~*iv. A criminal background check will be obtained. (10-1-94)*~~

05. ~~***Recipient's***~~ **Participant's Choice**. ~~*The choice of whether or not to receive TSC services will be the eligible recipient's. All recipients who choose TSC services will have free choice of authorized TSC providers, as well as, the providers of medical and other services under the Medicaid Program.*~~ The participant may choose to receive or not to receive TSC services. The participant has the choice of: ~~*(10-1-94)*~~(10-1-03)T

a. Developing and monitoring his own plan of service, with the choice of using service coordination; or (10-1-03)T

b. Using the targeted service coordinator for plan development, monitoring, and service coordination; or (10-1-03)T

c. Selecting a non-paid plan developer, and receiving plan monitoring and service coordination by a targeted service coordinator. (10-1-03)T

06. Payment For Services. ~~*When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as TSC services, however the actual provision of the services does not constitute TSC. Medicaid will only reimburse for core services (Subsection 118.02) provided to members of the eligible target group by qualified staff.*~~ Payment for services includes the following conditions: ~~*(10-1-94)*~~(10-1-03)T

a. ~~*Payment for TSC will not duplicate payment made to public or private entities under other program authorities for the same purpose.*~~ Service coordination includes coordinating services and plan monitoring paid at a monthly rate. ~~*(10-1-94)*~~(10-1-03)T

b. Plan development is paid as a separate service on an hourly basis. (10-1-03)T

c. Plan monitoring is paid as a separate service on an hourly basis when there is no service coordination. (10-1-03)T

d. Targeted service coordinators, plan developers, and plan monitors may not deliver or be paid for direct services. (10-1-03)T

~~**b**~~**e.** Payment will not be made for TSC services provided to individuals who are inpatients in NFs, ICFs/MR~~s~~, or hospitals, except as follows. ~~(10-1-94)~~(10-1-03)T

i. Medicaid will reimburse for TSC on the same date a ~~*recipient*~~ participant is admitted or discharged from NF, ICF/MR or other institutional setting, as long as the ~~*recipient*~~ participant is not yet admitted or has been discharged at the time of the service delivery. ~~(10-1-94)~~(10-1-03)T

ii. TSC may be provided during the last thirty (30) days of inpatient stay or when the inpatient stay is not expected to last longer than thirty (30) days when not duplicating those services included in the responsibilities of the facility. (10-1-94)

~~*c. Reimbursement for TSC services shall be made at rates established by the Department. (12-1-02)T*~~

~~**d**~~**f.** The Department will not provide Medicaid reimbursement for on-going TSC services delivered prior to the completion of assessments and ~~*ISP*~~ plan of service. ~~(10-1-94)~~(10-1-03)T

~~*e. The Department will provide Medicaid reimbursement for crisis assistance provided prior to or after the completion of the assessments and ISP. (10-1-94)*~~

~~**f**~~**g.** Medicaid reimbursement will be provided only for the following TSC services: (10-1-94)

i. Face-to-face contact between the service coordinator and the ~~*recipient*~~ participant, the ~~*recipient's*~~ participant's family members, guardian, service providers, legal representatives, primary caregivers, or other interested persons; ~~(10-1-94)~~(10-1-03)T

ii. Telephone contact between the service coordinator and the ~~*recipient*~~ participant, the ~~*recipient's*~~ participant's family, guardian, service providers, legal representatives, primary caregivers, or other interested persons; ~~(10-1-94)~~(10-1-03)T

iii. Plan ~~*D*~~development, review, ~~*revision of the ISP.*~~ and addenda as needed, if the service coordinator is chosen as the plan developer; ~~(10-1-94)~~(10-1-03)T

~~**g**~~**h.** The provider will provide the Department with access to all information required to review compliance with these rules. (1-7-94)

~~**h**~~**i.** Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of payments for services, sanctions, or both. (1-7-94)

~~**i**~~**j.** The Department will not provide Medicaid reimbursement for TSC provided to a group of individuals. (10-1-94)

~~**j**~~**k.** The TSC agency must release all pertinent information to direct service providers when written informed consent is obtained from the ~~*recipient*~~ participant. ~~(5-24-95)~~(10-1-03)T

l. The targeted service coordinator may be paid separately for community crisis supports as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". (10-1-03)T

07. Record Requirements. In addition to the development and maintenance of the ~~*ISP*~~ plan of service, the following documentation must be maintained by the provider: ~~(10-1-94)~~(10-1-03)T

a. Name of ~~*recipient*~~ participant; ~~(1-7-94)~~(10-1-03)T

b. Name of provider agency and person providing the service; (1-7-94)

c. Date, time, and duration of service; (1-7-94)

d. Place of service delivery; (1-7-94)

e. Activity record describing the service(s) provided; (1-7-94)

f. Documented review of progress toward each service plan goal, and assessment of the ~~*recipient's*~~ participant's need for TSC and other services as the ~~*recipient's*~~ participant's needs change; ~~*(10-1-94)*~~(10-1-03)T

g. Documentation using the Department-required form justifying the provision of community crisis ~~*assistance*~~ supports to the ~~*recipient*~~ participant; and ~~*(1-7-94)*~~(10-1-03)T

h. An informed consent form clearly explaining the purpose of the TSC and signed by the ~~*recipient*~~ participant or legal guardian~~*clearly explaining the purpose of TSC*~~. ~~*(10-1-94*~~(10-1-03)T

119. (RESERVED).

120. REHABILITATIVE SERVICES -- DEVELOPMENTAL DISABILITIES AGENCIES.
~~*The Department will pay for rehabilitative services pursuant to*~~ Under 42 CFR 440.130(d), the Department will pay for rehabilitative services including medical or remedial services provided by facilities ~~*which*~~ that have entered into a provider agreement with the Department and are licensed as developmental disabilities agencies by the ~~*Division of Family and Community Services, Bureau of Developmental Disabilities*~~ Department. ~~*Effective July 1, 1995, all recipients not currently receiving services from a Developmental Disabilities Agency shall do so only as part of an Individual Support Plan (ISP) developed by the client and his targeted service coordinator, if one is selected. If the client chooses not to select a targeted service coordinator, the Developmental Disabilities Agency (DDA) must ensure an Individual Program Plan is developed. Clients who are Home and Community Based Services Waiver recipients who want and need DDA services shall develop an ISP with their targeted service coordinator and submit that plan to the Regional ACCESS Unit for authorization. Educational services, other than those "related services" found in 34 CFR 300.13 and provided to all eligibles under the State Medical Plan, are the responsibility of the public schools and are not eligible for Medicaid payments. Covered "related services" include: audiology; psychotherapy services; physician services; developmental and occupational therapy; physical therapy; speech pathology and transportation necessary to obtain other covered services.*~~ ~~*(3-30-01)*~~(10-1-03)T

01. Requirement For Plan Of Service And Prior Authorization. All services for adults with developmental disabilities and ISSH waiver participants must be identified on the plan of service and prior authorized as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services," Sections 200 through 320. (10-1-03)T

02. Individual Program Plan Requirement. All services for children must be identified on the Individual Program Plan developed by the developmental disabilities agency (DDA) as described in IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies". (10-1-03)T

0~~1~~3. Evaluation And Diagnostic Services. ~~*Prior to delivery of service, current and accurate comprehensive evaluations or specific skill assessment shall be completed or obtained as necessary to effectively plan the consumer's program. Evaluations and assessments shall reflect the current status of the consumer. (3-30-01)*~~

~~***a.***~~ ~~*When required m*~~Medical/social, psychological, speech and hearing, physical, developmental, and occupational therapy evaluations must meet the requirements of IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies~~;~~". ~~*with the following exceptions:*~~ ~~*(3-30-01)*~~

~~*i. For children being served in a Developmental Disabilities Agency under Part C of IDEA (Individuals with Disabilities Education Act), the above evaluations must meet the requirements in Title 16, Chapter 1, Idaho Code, "Early Intervention Services" and the Idaho State Plan for Early services Intervention of the Individuals with Developmental Disabilities Education Act; or (3-30-01)*~~

~~*ii. For children being served in a Developmental Disabilities Agency under Part B of IDEA, the above evaluations must meet Section 33-201, Idaho Code, "School Age," and IDAPA 08.02.03, "Rules Governing*~~

~~*Thoroughness".*~~ ~~*(3-30-01)*~~

~~***b.***~~ Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all evaluation or diagnostic services provided in any calendar year. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. ~~*(10-6-88)*~~(10-1-03)T

0~~2~~4. **Treatment Services**. ~~*Home, community and center based*~~ Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in ~~*an ISP submitted to the Regional ACCESS Unit*~~ IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies". The treatment services listed below in Subsections 120.04.a. through 120.04.e. of this rule and community supported employment must not be authorized for more than forty (40) hours per week. Covered treatment services include the following therapies: ~~*(3-30-01)*~~(10-1-03)T

a. ~~*The treatment services must meet the requirements of IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies," with the following exceptions:*~~ Developmental Therapy. Developmental therapy may be delivered in a Developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. ~~*(3-30-01)*~~(10-1-03)T

~~*i. For children being served in a Developmental Disabilities Agency under Part C of IDEA, treatment services must meet the requirements in Title 16, Chapter 01, Idaho Code, "Early Intervention Services" and the Idaho State Plan for Early Intervention of the Individuals with Developmental Disabilities Education Act; or*~~ ~~*(3-30-01)*~~

~~*ii. For children being served in a Developmental Disabilities Agency under Part B of IDEA, treatment services must meet Section 33-201, Idaho Code, "School Age," and IDAPA 08.02.03, "Rules Governing Thoroughness".*~~ ~~*(3-30-01)*~~

b. Psychotherapy Services. Psychotherapy services are limited to a maximum of forty-five (45) hours in a calendar year, and include: ~~*(7-1-95)*~~(10-1-03)T

i. Individual psychotherapy; (7-1-95)

ii. Group psychotherapy; and ~~*(7-1-95)*~~(10-1-03)T

iii. Family-centered psychotherapy which must include the ~~*recipient*~~ participant and one (1) other family member at any given time. ~~*(7-1-95)*~~(10-1-03)T

c. Speech and Hearing Therapy Services. Speech and hearing therapy services are limited to two hundred fifty (250) treatment sessions per calendar year. ~~*(7-1-95)*~~(10-1-03)T

d. Physical Therapy. Physical therapy services are limited in accordance with Section 140 of these rules. ~~*(3-30-01)*~~(10-1-03)T

e. ~~*Developmental and occupational therapy services alone or in combination are limited to a maximum of thirty (30) hours per week.*~~ Occupational Therapy. Occupational therapy includes individual occupational therapy and group occupational therapy. ~~*(3-30-01)*~~(10-1-03)T

f. Intensive Behavioral Intervention (IBI). Intensive behavioral intervention includes individual intensive behavioral intervention and intensive behavioral intervention consultation. (10-1-03)T

~~***f***~~**g.** Collateral Contact. Collateral contact is contact with individuals directly involved with the ~~*recipient of*~~ participant receiving the service to ~~*expand rehabilitative services into the client's living location*~~ promote understanding of each person's therapeutic objectives and consistency among persons having direct contact with the

program participant. Such contacts will be included in the limitations of hours of treatment service reimbursed by Medicaid. Contacts with such persons for the purpose of future placement, interagency and intra-agency case monitoring, staffings and social service activities are not allowable for Medicaid payment. ~~*(10-6-88)*~~(10-1-03)T

~~*g*~~**h.** ~~*Intensive Behavioral Interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. Intensive Behavioral Intervention is available only to children birth through age twenty-one (21) who have self-injurious, aggressive, or severely maladaptive behavior and severe deficits in the areas of verbal and non-verbal communication; or social interaction; or leisure and play skills. Intensive Behavioral Intervention alone or in combination with developmental and occupational therapy is limited to thirty (30) hours a week and may be delivered for no longer than thirty-six (36) months.~~ Except in the case of a child prior authorized for additional therapy hours through the EPSDT program, the services of developmental therapy, occupational therapy, and intensive behavioral intervention are limited to no more than thirty (30) hours per week either alone or in combination. ~~*(3-15-02)*~~(10-1-03)T

~~*h*~~**i.** Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the ~~*recipient*~~ participant is being transported to and from the agency. ~~*(3-30-01)*~~(10-1-03)T

~~***03. Optional Services.***~~ ~~*(11-22-91)*~~

~~***a.*** *Consultation for the purpose of prescribing, monitoring, and/or administering medications. These consultations shall be:*~~ ~~*(11-22-91)*~~

~~*i. Provided by a physician or licensed nurse practitioner in direct face-to-face contact with the client; and*~~ ~~*(11-22-91)*~~

~~*ii. Incorporated into the client's Individual Support Plan with the type, amount, and duration of the service specified.*~~ ~~*(7-1-95)*~~

~~***b.*** *Nursing services for the purpose of supervising, monitoring, and/or administering medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code. These services shall be:*~~ ~~*(11-22-91)*~~

~~*i. Ordered and supervised by a physician; and*~~ ~~*(11-22-91)*~~

~~*ii. Provided by licensed and qualified nursing personnel in direct face-to-face contact with the client; and*~~ ~~*(11-22-91)*~~

~~*iii. Incorporated into the client's Individual Support Plan with the type, amount, and duration of the service specified.*~~ ~~*(7-1-95)*~~

~~***c.*** *Psychiatric evaluations and services for the purpose of establishing a diagnosis, identifying client strengths and needs, and recommending and/or implementing interventions to address each need. These evaluations and services shall be:*~~ ~~*(11-22-91)*~~

~~*i. Conducted by a physician in direct face-to-face contact with the client; and*~~ ~~*(11-22-91)*~~

~~*ii. Incorporated into the client's Individual Support Plan with the type, amount, and duration of service specified.*~~ ~~*(7-1-95)*~~

~~***04. Requirements For Agencies****. Agencies must be licensed as Developmental Disabilities Agencies by the Department. Loss of licensure by an agency will be cause for termination of all Medicaid program payment for services and termination of the agency's provider agreement.*~~ ~~*(3-30-01)*~~

05. Excluded Services. The following services are excluded for Medicaid payments: (10-6-88)

a. Vocational services; and (10-6-88)

b. Educational services; and (10-6-88)

c. Recreational services. (10-6-88)

06. Payment Procedures. Payment for agency services must be in accordance with rates established by the Department. (3-30-01)

a. Providers of services must accept as payment in full the Department's payment for such services and must not bill a ~~*MA recipient*~~ Medicaid participant for any portion of any charges. ~~*(11-10-81)*~~(10-1-03)T

b. Third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible ~~*recipient*~~ participant. Proof of billing other third party payors is required. ~~*(11-10-81)*~~(10-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

143. WAIVER SERVICES FOR ADULTS WITH DEVELOPMENTAL~~*LY*~~ DISABILITIE~~*D*~~S ~~*RECIPIENTS*~~ AND ISSH WAIVER PARTICIPANTS.
~~*Pursuant to*~~ Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible ~~*recipients in order*~~ participants to prevent unnecessary institutional placement, ~~*to*~~ provide for the greatest degree of independence possible, ~~*to*~~ enhance the quality of life, ~~*to*~~ encourage individual choice, and ~~*to*~~ achieve and maintain community integration. For a ~~*recipient*~~ participant to be eligible, the Department must find that the ~~*recipient*~~ participant requires services due to a developmental disability ~~*which*~~ that impairs ~~*their*~~ his mental or physical function or independence, ~~*be*~~ is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/MR. ~~*(7-1-95)*~~(10-1-03)T

01. Services Provided. (7-1-95)

a. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible ~~*recipients*~~ participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: ~~*(7-1-97)*~~(10-1-03)T

i. Habilitation services aimed at assisting the individual to acquire, retain or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (7-1-97)

(1) Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (7-1-95)

(2) Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (7-1-95)

(3) Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (7-1-95)

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

specific training activities necessary to assist the ~~*recipient*~~ participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities which are merely diversional or recreational in nature); ~~*(7-1-95)*~~(10-1-03)T

(5) Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (7-1-95)

(6) Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (7-1-95)

ii. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the ~~*recipient*~~ participant or the ~~*recipient's*~~ participant's primary caregiver(s) are unable to accomplish on his own behalf. ~~*(7-1-95)*~~(10-1-03)T

iii. Skills training to teach waiver ~~*recipients*~~ participants, family members, alternative family caregiver(s), or a ~~*recipient's*~~ participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. ~~*(7-1-95)*~~(10-1-03)T

b. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the ~~*recipient's*~~ participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the ~~*recipient*~~ participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the ~~*recipient*~~ participant. ~~*(7-1-95)*~~(10-1-03)T

c. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to ~~*recipients*~~ participants who reside with non-paid caregivers. ~~*(4-5-00)*~~(10-1-03)T

d. Supported employment which is competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (7-1-95)

i. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available~~/~~ or funded under the Rehabilitation Act of 1973 as amended, or IDEA. ~~*(4-5-00)*~~(10-1-03)T

ii. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver ~~*recipients*~~ participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. ~~*(7-1-95)*~~(10-1-03)T

e. Transportation services which are services offered in order to enable waiver ~~*recipients*~~ participants to gain access to waiver and other community services and resources required by the ~~*individual support*~~ plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State ~~*p*~~Plan, defined at 42 CFR 440.170(a), and ~~*shall*~~ must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. ~~*(7-1-95)*~~(10-1-03)T

f. Environmental ~~*modifications*~~ accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver ~~*recipient's support*~~ participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver ~~*recipient*~~ participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver ~~*recipient*~~ participant, but ~~*shall*~~ must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the ~~*recipient*~~ participant, such as carpeting, roof repair, or central air conditioning. All services ~~*shall*~~ must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the ~~*recipient*~~ participant or the ~~*recipient's*~~ participant's family when the home is the ~~*recipient's*~~ participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the ~~*recipient*~~ participant to his next place of residence or be returned to the Department. ~~*(7-1-95)*~~(10-1-03)T

g. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the ~~*Individual Support P*~~plan of service which enable ~~*recipients*~~ participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State ~~*p*~~Plan. Items reimbursed with waiver funds ~~*shall*~~ must be in addition to any medical equipment and supplies furnished under the State ~~*p*~~Plan and ~~*shall*~~ must exclude those items which are not of direct medical or remedial benefit to the ~~*recipient*~~ participant. All items ~~*shall*~~ must meet applicable standards of manufacture, design and installation. ~~*(7-1-95)*~~(10-1-03)T

h. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver ~~*recipient*~~ participant safety and/or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to ~~*recipients*~~ participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. ~~*(7-1-95)*~~(10-1-03)T

i. Home delivered meals which are designed to promote adequate wavier ~~*recipient*~~ participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to ~~*recipients*~~ participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. ~~*(7-1-97)*~~(10-1-03)T

~~***j.*** *Therapy services under the waiver include physical therapy services; occupational therapy services; and speech, hearing and language services. These services are to be available through the waiver when the need for such services exceeds the therapy limitations under the State plan. Under the waiver, therapy services will include:* *(7-1-97)*~~

~~*i.* *Services provided in the waiver recipient's residence, day habilitation site, or supported employment site;* *(7-1-95)*~~

~~*ii.* *Consultation with other service providers and family members;* *(7-1-95)*~~

~~*iii.* *Participation on the recipient's Individual Support Plan team.* *(7-1-97)*~~

~~***k***~~**j.** Nursing services are those intermittent nursing services or private duty nursing services which

provide individual and continuous care listed in the ~~*Individual Support P*~~plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed ~~*registered*~~ professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an ~~*registered nurse*~~ RN, licensed to practice in Idaho. ~~*(7-1-95)*~~(10-1-03)T

~~*l*~~**k.** Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of ~~*recipients*~~ participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a ~~*recipient*~~ participant. These services also provide emergency back-up involving the direct support of the ~~*recipient*~~ participant in crisis. ~~*(7-1-97)*~~(10-1-03)T

~~*m*~~**l.** Adult Day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the ~~*Individual Support P*~~plan of service. Adult Day Care can not exceed thirty (30) hours per week either alone or in combination with ~~*D*~~developmental ~~*T*~~therapy, occupational therapy, or IBI. ~~*(4-5-00)*~~(10-1-03)T

i. Services provided in a facility must meet the building and health standards identified in IDAPA 16.04.11, "Rules Governing Developmental Disability Agencies," Sections 920 and 921. (4-5-00)

ii. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.04.11, "Rules Governing Developmental Disability Agencies" Section 921. (4-5-00)

02. Place Of Service Delivery. Waiver services ~~*for developmentally disabled recipients*~~ may be provided in the ~~*recipient's*~~ participant's personal residence, ~~*specialized*~~ a certified family home, ~~*waiver facilities,*~~ day habilitation/supported employment program, or community. The following living situations are specifically excluded as a ~~*personal residence*~~ place of service for ~~*the purpose of these rules*~~ waiver services: ~~*(7-1-95)*~~(10-1-03)T

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (7-1-95)

b. Licensed Intermediate Care Facility for ~~*the*~~ persons with Mental~~*ly*~~ Retard~~*ed*~~ation (ICF/MR); and ~~*(7-1-95)*~~(10-1-03)T

c. Licensed Residential ~~*and*~~ or Assisted Living Facility. ~~*(4-5-00)*~~(10-1-03)T

d. Additional limitations to specific services are listed under that service definition. (7-1-95)

03. Authorization Of Services ~~*Delivered Following*~~ On A Written Plan. All waiver services must be identified on the plan of service and authorized by the ~~*ACCESS Unit in the Region where the recipient will be residing and provided based on a written Individual Support Plan (ISP)*~~ process described in IDAPA 16.03.13, "Prior Authorization of Behavioral Health Services," Sections 200 through 320. The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. ~~*(7-1-95)*~~(10-1-03)T

~~***a.*** *The ISP is developed by the ISP team which includes:* *(7-1-95)*~~

~~*i. The waiver recipient. Efforts must be made to maximize the recipient's participation on the team by providing him with information and education regarding his rights; and* *(7-1-95)*~~

~~*ii. The service coordinator chosen by the recipient; and* *(7-1-95)*~~

~~*iii. The guardian when appropriate; and* *(7-1-95)*~~

~~*iv. May include others identified by the waiver recipient.* *(7-1-95)*~~

~~***b.*** *The ISP must be based on a person-centered planning and assessment process approved by the*~~

~~*Department.*~~ ~~*(7-1-95)*~~

~~***c.*** *The ISP must include the following:*~~ ~~*(7-1-95)*~~

~~*i.* *The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; and*~~ ~~*(7-1-95)*~~

~~*ii.* *Supports and service needs that are to be met by the recipient's family, friends and other community services; and*~~ ~~*(7-1-95)*~~

~~*iii.* *The providers of waiver services when known; and*~~ ~~*(7-1-95)*~~

~~*iv.* *Documentation that the recipient has been given a choice between waiver services and institutional placement; and*~~ ~~*(7-1-95)*~~

~~*v.* *The signature of the recipient or his legal representative and the service coordinator.*~~ ~~*(7-1-95)*~~

~~***d.*** *The plan must be reviewed monthly by the ISP team. Revisions and updates are made based upon treatment results or a change in the recipient's needs. A new plan must be developed and approved annually.*~~ ~~*(4-5-00)*~~

~~***04.*** ***Authorization Of Services****. All services reimbursed under the Home and Community Based Waiver for Developmentally Disabled must be authorized prior to the payment of services by the Regional ACCESS Unit.*~~ ~~*(7-1-95)*~~

0~~5~~4. **Service Supervision**. The ~~*Individual Support P*~~plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. ~~*(7-1-95)*~~(10-1-03)T

0~~6~~5. **Provider Qualifications**. All providers of waiver services must have a valid provider agreement~~/ *performance contract*~~ with the Department. Performance under this agreement~~/*contract*~~ will be monitored by the ~~*ACCESS Unit in each region*~~ Department. ~~*(7-1-95)*~~(10-1-03)T

a. Residential ~~*H*~~habilitation services must be provided by an agency that is certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and is capable of supervising the direct services provided. Individuals who provide twenty-four (24) hour services in their own home ~~*and are*~~ must be certified by the Department as a ~~*C*~~certified ~~*F*~~family ~~*H*~~home ~~*(CFH)*~~ and must be affiliated with a Residential Habilitation Agency. The Residential Habilitation Agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide ~~*R*~~residential ~~*H*~~habilitation services in the home of the ~~*consumer*~~ participant (supp~~*p*~~orted living), must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: ~~*(5-3-03)*~~(10-1-03)T

i. Direct service staff must meet the following minimum qualifications: (10-1-03)T

(1) ~~*b*~~Be at least eighteen (18) years of age; (10-1-03)T

(2) ~~*b*~~Be a high school graduate or have a GED or demonstrate the ability to provide services according to an ~~*Individual Support P*~~plan of service; (10-1-03)T

(3) ~~*h*~~Have current CPR and First Aid certifications; be free from communicable diseases; (10-1-03)T

(4) ~~*p*~~Pass a criminal background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". ~~*(w*~~When residential habilitation services are provided in a certified family home, all adults living in the home must pass a ~~*C*~~criminal ~~*H*~~history ~~*C*~~check~~*)*~~; (10-1-03)T

(5) ~~*p*~~Participate in an orientation program, including the purpose and philosophy of services, service rules, policies and procedures, proper conduct in relating to waiver participants, and handling of confidential and

emergency situations that involve the waiver participant, provided by an agency prior to performing services; and (10-1-03)T

(6) ~~h~~Have appropriate certification or licensure if required to perform tasks which require certification or licensure. ~~*The provider agency will be responsible for providing training specific to the needs of the recipient.*~~ ~~*(5-3-03)*~~(10-1-03)T

ii. The provider agency will be responsible for providing training specific to the needs of the ~~*recipient*~~ participant. Skill training must be provided by a Qualified Mental Retardation Professional (QMRP) who has demonstrated experience in writing skill training programs. Additional training requirements must include at a minimum: ~~*(4-5-00)*~~(10-1-03)T

(1) Instructional technology; (4-5-00)

(2) Behavior technology; (4-5-00)

(3) Feeding; (4-5-00)

(4) Communication/sign language; (4-5-00)

(5) Mobility; (4-5-00)

(6) Assistance with medications (training in assistance with medications must be provided by a licensed nurse); (4-5-00)

(7) Activities of daily living; (4-5-00)

(8) Body mechanics and lifting techniques; (4-5-00)

(9) Housekeeping techniques; and (4-5-00)

(10) Maintenance of a clean, safe, and healthy environment. (4-5-00)

iii. When residential habilitation services are provided in the provider's home, the provider's home must meet the requirements ~~*as identified*~~ in IDAPA 16.03.19, "Rules Governing Certified Family Homes". Non-compliance with the certification process ~~*will be*~~ is cause for termination of the provider's provider agreement. ~~*(5-3-03)*~~(10-1-03)T

b. Providers of chore services must meet the following minimum qualifications: (7-1-95)

i. Be skilled in the type of service to be provided; and (7-1-95)

ii. Demonstrate the ability to provide services according to a~~*n individual support*~~ plan of service. ~~*(7-1-95)*~~(10-1-03)T

c. Providers of respite care services must meet the following minimum qualifications: (7-1-95)

i. Meet the qualifications prescribed for the type of services to be rendered~~*, for instance Residential Habilitation providers,*~~ or must be an individual selected by the waiver participant and/or the family or guardian; ~~*and*~~ ~~*(7-1-95)*~~(10-1-03)T

ii. Have received caregiving instructions in the needs of the person who will be provided the service; ~~*and*~~ ~~*(7-1-95)*~~(10-1-03)T

iii. Demonstrate the ability to provide services according to an ~~*individual support*~~ plan of service; ~~*and*~~ ~~*(7-1-95)*~~(10-1-03)T

iv. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; ~~*and*~~ ~~*(7-1-95)*~~(10-1-03)T

v. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (7-1-95)

vi. Be free of communicable diseases. (7-1-95)

d. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider (7-1-95)

e. Providers of transportation services must: (7-1-95)

i. Possess a valid driver's license; and (7-1-95)

ii. Possess valid vehicle insurance. (7-1-95)

f. Environmental ~~*Modifications*~~ accessibility adaptations services must: ~~*(7-1-95)*~~(10-1-03)T

i. Be done under a permit, if required; and (7-1-95)

ii. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (7-1-95)

g. Specialized Equipment and Supplies purchased under this service must: (7-1-95)

i. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (7-1-95)

ii. Be obtained or provided by authorized dealers of the specific product where applicable. ~~*For instance,*~~ This may include medical supply businesses or organizations that specialize in the design of the equipment. ~~*(7-1-95)*~~(10-1-03)T

h. Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. ~~*(7-1-95)*~~(10-1-03)T

i. Services of Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (7-1-95)

i. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; ~~*and*~~ ~~*(7-1-97)*~~(10-1-03)T

~~*ii. Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes; and (7-1-95)*~~

ii~~*i*~~. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; ~~*and*~~ ~~*(7-1-97)*~~(10-1-03)T

i~~*v*~~ii. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; ~~*and*~~ ~~*(7-1-95)*~~(10-1-03)T

iv. Provide documentation of current driver's license for each driver; and (7-1-95)

v~~*i*~~. Must be inspected and licensed as a food establishment by the District Health Department. (7-1-95)

~~***j.*** *All therapy services, with the exception of physical therapy, must be provided by a provider agency capable of supervising the direct service. Providers of services must meet the provider qualifications listed in the State Plan.*~~ ~~*(7-1-95)*~~

~~***k***~~**j.** Nursing ~~*S*~~service ~~*P*~~providers must provide documentation of current Idaho licensure as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. ~~*(7-1-95)*~~(10-1-03)T

~~***l***~~**k.** Behavior Consultation/Crisis Management Providers must meet the following: (7-1-95)

i. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (7-1-95)

ii. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (7-1-95)

iii. Be a licensed pharmacist; or (7-1-95)

iv. Be a Qualified Mental Retardation Professional (QMRP). ~~*(7-1-97)*~~(10-1-03)T

v. Emergency back-up providers must meet the minimum residential habilitation provider qualifications ~~*under Residential Habilitation services*~~ described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies". ~~*(7-1-95)*~~(10-1-03)T

~~***m***~~**l.** Providers of adult day care services ~~*work for a provider*~~ must be employed by or be affiliated with the residential habilitation agency that provides program coordination for the participant if the service is provided to a single participant in a certified family home other that the participant's primary residence, be capable of supervising direct services, provide services as identified on the ~~*Individual Support P*~~plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: ~~*(4-5-00)*~~(10-1-03)T

i. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (4-5-00)

ii. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the ~~*Individual Support P*~~plan of service; ~~*(4-5-00)*~~(10-1-03)T

iii. Be free from communicable disease; (4-5-00)

iv. Pass a ~~*C*~~criminal ~~*H*~~history ~~*C*~~check as required by IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"; ~~*(4-5-00)*~~(10-1-03)T

v. Demonstrate knowledge of infection control methods; and (4-5-00)

vi. Agree to practice confidentiality in handling situations that involve waiver participants. (4-5-00)

0~~7~~6. ~~***Recipient***~~ **Participant Eligibility Determination**. Waiver eligibility will be determined by the ~~*Regional ACCESS Unit*~~ Department as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". The ~~*recipient*~~ participant must be financially eligible for MA as described in IDAPA 16.03.05, Section 787, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)". The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver ~~*recipients*~~ participants must meet the following requirements: ~~*(4-5-00)*~~(10-1-03)T

a. ~~*Recipient*~~ DD waiver participants must be eighteen (18) years of age or older. ISSH waiver participants must be fifteen (15) years of age through the month of their eighteenth birthday. ~~*(4-5-00)*~~(7-15-03)T

b. The ~~*Regional ACCESS Unit*~~ Department or its designee must determine that: ~~*(7-1-95)*~~(10-1-03)T

i. The ~~*recipient*~~ participant would qualify for ICF/MR level of care as set forth in Section 610 of these rules, if the waiver services listed in Section 143 of these rules were not made available; and ~~*(5-3-03)*~~(10-1-03)T

ii. The ~~*recipient*~~ participant could be safely and effectively maintained in the requested~~/~~ or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the ~~*ISP*~~ person-centered planning team; and prior to any denial of services on this basis, be determined by the ~~*Service Coordinator*~~ plan developer that services to correct the concerns of the team are not available. ~~*(7-1-95)*~~(10-1-03)T

iii. The average ~~*daily*~~ annual cost of waiver services and other medical services to the ~~*recipient*~~ participant would not exceed the average ~~*daily*~~ annual cost to Medicaid of ICF/MR care and other medical costs. ~~*Individual recipients whose cost of services exceeds this average may be approved on a case by case basis that assures that the average per capita expenditures under the waiver do not exceed one hundred percent (100%) of the average per capita expenditures for ICF/MR care under the State plan that would have been made in that fiscal year had the waiver not been granted. This approval will be made by a team identified by the Administrators of the Divisions of Medicaid and Family and Community Services.*~~ ~~*(7-1-97)*~~(10-1-03)T

iv. Following the approval by the ~~*ACCESS Unit*~~ Department for services under the waiver, the ~~*recipient*~~ participant must receive and continue to receive a waiver service as described in these rules. A ~~*recipient*~~ participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. ~~*(7-1-95)*~~(10-1-03)T

c. A ~~*recipient*~~ participant who is determined by the ~~*ACCESS Unit*~~ Department to be eligible for services under the Home and Community Based Services Waivers for ~~*developmentally disabled*~~ ISSH and DD may elect to not utilize waiver services but may choose admission to an ICF/MR. ~~*(7-1-95)*~~(10-1-03)T

d. The ~~*recipient's eligibility examiner*~~ participant's self-reliance staff will process the application in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," as if the application was for admission to an ICF/MR, except that the ~~*eligibility examiner*~~ self-reliance staff will forward potentially eligible applications immediately to the ~~*ACCESS Unit*~~ Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. ~~*(4-5-00)*~~(10-1-03)T

e. The decisions of the ~~*ACCESS Unit*~~ Department or its designee regarding the acceptance of the ~~*recipients*~~ participants into the waiver program will be transmitted to the ~~*eligibility examiner*~~ self-reliance staff. ~~*(7-1-95)*~~(10-1-03)T

08. Case Redetermination. (7-1-95)

a. Financial redetermination will be conducted pursuant to IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)". Medical redetermination will be made at least annually by the ~~*ACCESS Unit*~~ Department, or sooner at the request of the ~~*recipient*~~ participant, the ~~*eligibility examiner*~~ self-reliance staff, provider agency or physician. The sections cited implement and are in accordance with Idaho's approved ~~*s*~~State ~~*p*~~Plan with the exception of deeming of income provisions. ~~*(4-5-00)*~~(10-1-03)T

b. The redetermination process will assess the following factors: (7-1-95)

i. The ~~*recipient's*~~ participant's continued need and eligibility for waiver services; and ~~*(7-1-95)*~~(10-1-03)T

ii. Discharge from the waiver services program. (7-1-97)

0~~9~~8. Provider Reimbursement. (7-1-95)

a. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (7-1-95)

b. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (7-1-95)

c. The ~~*fees*~~ reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the ~~*recipient's*~~ participant's home or other service delivery location when the ~~*recipient*~~ participant is not being provided transportation. ~~*(7-1-95)*~~(10-1-03)T

~~**1**~~**09.** **Provider Records**. Three (3) types of record information will be maintained on all ~~*recipients*~~ participants receiving waiver services: ~~*(7-1-97)*~~(10-1-03)T

a. Direct Service Provider Information which includes written documentation of each visit made or service provided to the ~~*recipient*~~ participant, and will record at a minimum the following information: ~~*(7-1-95)*~~(10-1-03)T

i. Date and time of visit; and (7-1-95)

ii. Services provided during the visit; and (7-1-95)

iii. A statement of the ~~*recipient's*~~ participant's response to the service, if appropriate to the service provided, including any changes in the ~~*recipient's*~~ participant's condition; and ~~*(7-1-95)*~~(10-1-03)T

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the ~~*recipient*~~ participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the ~~*recipient*~~ participant as evidenced by their signature on the service record. ~~*(7-1-95)*~~(10-1-03)T

v. A copy of the above information will be maintained in the ~~*recipient's*~~ participant's home unless authorized to be kept elsewhere by the ~~*ACCESS Unit*~~ Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. ~~*(7-1-97)*~~(10-1-03)T

b. The ~~*individual support*~~ plan ~~*which is initiated by the ACCESS Unit and*~~ of service developed by the ~~*Service Coordinator*~~ plan developer and the ~~*ISP*~~ person-centered planning team must specify which ~~*waiver*~~ services are required by the ~~*recipient*~~ participant. The plan ~~*will*~~ of service must contain all elements required by Subsection 143.03 of these rules and a copy of the most current ~~*individual support*~~ plan ~~*will*~~ of service must be maintained in the ~~*recipient's*~~ participant's home and ~~*will*~~ must be available to all service providers and the Department. ~~*(7-1-95)*~~(10-1-03)T

c. In addition to the ~~*individual support*~~ plan of service, ~~*at least monthly the service coordinator will verify in writing, that the services provided were consistent with the individual support plan. Any changes in the plan will be documented and include the signature of the service coordinator and when possible, the recipient*~~ all providers, with the exception of chore, non-medical transportation, and enrolled Medicaid vendors, must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services". ~~*(7-1-95)*~~(10-1-03)T

~~**1**~~**10.** **Provider Responsibility For Notification**. It is the responsibility of the service provider to notify the service coordinator or plan developer when any significant changes in the ~~*recipient's*~~ participant's condition are noted during service delivery. Such notification will be documented in the service record. ~~*(7-1-95)*~~(10-1-03)T

~~**1**~~**11.** **Records Maintenance**. In order to provide continuity of services, when a ~~*recipient is transferred among*~~ participant changes service providers, plan developers, or ~~*when a recipient changes*~~ service coordinators, all of the foregoing ~~*recipient*~~ participant records will be delivered to and held by the ~~*Regional ACCESS Unit*~~ Department until a replacement service provider, plan developer, or service coordinator ~~*assumes the case*~~ is selected by the participant. When a ~~*recipient*~~ participant leaves the waiver services program, the records will be retained by the

~~*Regional ACCESS Unit*~~ Department as part of the ~~*recipient's*~~ participant's closed case record. Provider agencies will be responsible to retain their client's records for three (3) years following the date of service. ~~*(7-1-97)*~~(10-1-03)T

1~~3~~2. Home And Community-Based Waiver ~~*Recipient*~~ Participant Limitations. The number of Medicaid ~~*recipients*~~ participants to receive waiver services under the home and community based waiver for developmentally disabled ~~*recipients*~~ participants will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30 for the DD waiver and after June 30 for the ISSH waiver of each new waiver year. ~~*The earliest effective date of waiver service delivery for these recipients will be October 1 of each new waiver year.*~~ ~~*(7-1-97)*~~(10-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

~~***656. REQUEST FOR RECONSIDERATION OF ICF/MR LEVEL OF CARE.***~~
~~*Persons who have been found to not be eligible for ICF/MR level of care may request a reconsideration by a team which includes administrative staff from the Division of Family and Community Services, the Division of Medicaid and Interdisciplinary Professionals who were not involved in the original eligibility decision prior to a request for fair hearing.*~~ ~~*(4-5-00)*~~

~~***01. Time Frame For Receiving Appeal.*** *An appeal for a administrative review must be received by the regional program fifteen (15) days from the regional denial. This action does not replace the right to a fair hearing.*~~ ~~*(4-5-00)*~~

~~***02. Time Frame For Requesting Fair Hearing.*** *Persons who receive a denial from the Administrative Review may request a fair hearing within thirty (30) days of the administrative denial.*~~ ~~*(4-5-00)*~~

65~~7~~6. -- 659. (RESERVED).

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0308

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b), 56-203(g) and 56-209h, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the October 1, 2003 Idaho Administrative Bulletin, Volume 03-10, pages 248 through 254.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mond Warren at (208) 334-5997.

DATED this 29th day of October, 2003.

Sherri Kovach
Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax
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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-10, October 1, 2003, pages 248 through 254.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0308

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules are effective October 1, 2003.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), and 56-209h, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2003.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

These rules are being amended to help the Department respond and protect program participants from abuse or neglect. The rule is being amended to clarify the Department has the right to immediate access of records and copying of those records for investigation of fraud or abuse. Clarification is also being made on suspension of payments to align the Department's rules with federal regulations when investigating alleged fraud or abuse cases. Obsolete language is being deleted as well as updating audit and investigation procedures being used.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. Public comment should be addressed to these additions and deletions.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to protect the public health, safety and welfare.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:For assistance on technical questions concerning the temporary or proposed rule, contact Mond Warren at (208) 334-5997.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 22, 2003.

DATED this 8th day of August, 2003.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
450 West State Street, 10th Floor
P.O. Box 83720
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0308

201. DEFINITIONS - FRAUD, ABUSE AND MISCONDUCT.
For purposes of Sections 200 through 233, unless the context clearly requires otherwise, the following words and terms ~~*shall*~~ will have the following meanings: ~~*(4-5-00)*~~(10-1-03)T

01. Abuse Or Abusive. Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or in physical harm, pain or mental anguish to a medical assistance recipient. It also includes recipient practices that result in unnecessary cost to the Medicaid program, or recipient utilization practices which may endanger their personal health or safety. (4-5-00)

02. Access To Documentation And Records. To review and copy records at the time a written request is made during normal business hours. Documentation includes all materials as described in Section 202 of these rules. (10-1-03)T

0~~2~~3. Claim. Any request or demand for payment of items or services under the state's medical assistance program, whether under a contract or otherwise. (4-5-00)

0~~3~~4. Conviction. An individual or entity is considered to have been convicted of a criminal offense: (3-30-01)

a. When a judgment of conviction has been entered against the individual or entity by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (3-30-01)

b. When there has been a finding of guilt against the individual or entity by a federal, state, or local court; (3-30-01)

c. When a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court; or (3-30-01)

d. When the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld. (3-30-01)

0~~4~~5. Exclusion. A specific person or provider will be precluded from directly or indirectly providing services and receiving reimbursement under Medicaid. (4-5-00)

0~~5~~6. Fraud Or Fraudulent. An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. (4-5-00)

0~~6~~7. Knowingly, Known, Or With Knowledge. A person, with respect to information or an action, who: has actual knowledge of the information or an action; acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. (4-5-00)

0~~7~~8. Managing Employee. A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. (4-5-00)

0~~8~~9. Medical Assistance. Shall mean payments for part or all of the cost of such care and services allowable within the scope of Title XIX and XXI of the federal Social Security Act as amended as may be designated by Department rules. (4-5-00)

~~*09*~~**10.** **Ownership Or Control Interest**. A person or entity that: has an ownership interest totaling twenty-five percent (25%) or more in an entity; is an officer or director of an entity that is organized as a corporation; is a partner in an entity that is organized as a partnership; or is a managing member in an entity that is organized as a limited liability company. (4-5-00)

1~~0~~1. **Person**. An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. (4-5-00)

1~~1~~2. **Program**. The Medicaid Program or any part thereof, including Idaho's state plan. (4-5-00)

1~~2~~3. **Recoup And Recoupment**. ~~*That payment of provider claims will be withheld for the purpose of recovering funds which have been paid for items or services the Department has subsequently determined should not have been paid.*~~ The collection of funds for the purpose of recovering overpayments made to providers for items or services the Department has determined should not have been paid. The recoupment may occur through the collection of future claims paid or other means. ~~*(4-5-00)*~~(10-1-03)T

1~~3~~4. **Sanction**. Any abatement or corrective action taken by the Department which is appealable under Section 224 of these rules. (4-5-00)

1~~4~~5. **State Plan**. The Medicaid Program as it exists in Idaho. (4-5-00)

~~***15.*** ***Provider Suspension****. The temporary barring of a person from participation in the Medicaid program pending further investigation or additional action.* *(4-5-00)*~~

202. DOCUMENTATION OF SERVICES AND ACCESS TO RECORDS.

01. **Documentation Of Services**. Providers ~~*shall*~~ must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation ~~*shall*~~ must be legible and consistent with professionally recognized standards. Documentation ~~*shall*~~ must be retained for a period of five (5) years from the date the item or service was provided. ~~*The Department or its authorized agent shall be given immediate access to such documentation upon written request.*~~ Documentation to support claims for services includes, but is not limited to, medical records, treatment plans, medical necessity justification, assessments, appointment sheets, patient accounts, financial records or other records regardless of its form or media. ~~*(4-5-00)*~~(10-1-03)T

02. **Immediate Access To Records**. Providers must grant to the Department and its agents, the U.S. Department of Health and Human Services and its agents, immediate access to records for review and copying during normal business hours. These records are defined in Subsection 202.01 of these rules (10-1-03)T

03. **Copying Records**. The Department and its authorized agents may copy any record as defined in Subsection 202.01 of these rules. They may request in writing to have copies of records supplied by the provider. The requested copies must be furnished within twenty (20) working days after the date of the written request, unless an extension of time is granted by the Department for good cause. Failure to timely provide requested copies will be a refusal to provide access to records. (10-1-03)T

04. **Removal Of Records From Provider's Premises**. The Department and its authorized agents may remove from the provider's premises copies of any records as defined in Subsection 202.01 of these rules. (10-1-03)T

203. INVESTIGATION AND AUDITS.
Investigation and audits of provider fraud, abuse or misconduct conducted by the Department's Bureau of Audits and Investigations or its successor are governed under Sections 200 through 233 of these rules. (10-1-03)T

01. **Investigation Methods**. ~~*Pursuant to*~~ Under Section 56-227(e), Idaho Code, the Department ~~*shall*~~ will investigate and identify potential instances of fraud, abuse, or other misconduct by any person related to involvement in the program. Methods may include, but are not limited to, review of computerized reports, referrals to

or from other agencies, health care providers or persons, or conducting audits and interviews, probability sampling and extrapolation, and issuing subpoenas to compel testimony or the production of records. Reviews may occur on either pre-payment or post-payment basis. ~~*(3-30-01)*~~(10-1-03)T

02. Probability Sampling. Probability sampling shall be done in conformance with generally accepted statistical standards and procedures. "Probability sampling" means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events). (3-30-01)

03. Extrapolation. Whenever the results of a probability sample are used to extrapolate the amount to be recovered, the demand for recovery shall be accompanied by a clear description of the universe from which the sample was drawn, the sample size and method used to select the sample, the formulas and calculation procedures used to determine the amount to be recovered, and the confidence level used to calculate the precision of the extrapolated overpayment. "Extrapolation" means the methodology whereby an unknown value can be estimated by projecting the results of a probability sample to the universe from which the sample was drawn with a calculated precision (margin of error). (3-30-01)

204. ~~*SURVEILLANCE AND UTILIZATION REVIEW (S/UR) COMMITTEE*~~ (RESERVED).
~~*Instances of suspected fraud, abuse, or other misconduct may be referred to a review committee organized by the Department. The committee shall consist of health professionals and other staff appointed by the Director or his designee. The committee may also consult with other professionals as determined necessary by the committee. The function of the committee will be to review and make recommendations concerning corrective action.*~~ ~~*(4-5-00)*~~

205. DEPARTMENT ACTIONS.
When an instance of fraud, abuse, or other misconduct is identified, the Department ~~*shall*~~ will take action to correct the problem as provided in this section. Such corrective action may include, but is not limited to, denial of payment, recoupment, payment suspension, provider agreement suspension, termination of provider agreement, imposition of civil monetary penalties, exclusion, recipient lock-in, referral for prosecution, or referral to state licensing boards. ~~*(4-5-00)*~~(10-1-03)T

206. DENIAL OF PAYMENT.
~~*The Department may refuse to pay any and all claims it determines are for items or services:*~~ The following are reasons the Department may deny payment. ~~*(3-30-01)*~~(10-1-03)T

01. Billed Services Not Provided Or Not Medically Necessary. The Department may deny payment for any and all claims it determines are for items or services: (10-1-03)T

a. Not provided or not found by the Department to be medically necessary. ~~*(4-5-00)*~~(10-1-03)T

~~***02***~~**b.** ~~***Documentation.***~~ Not documented to be provided or medically necessary. ~~*(4-5-00)*~~(10-1-03)T

~~***03***~~**c.** ~~***Recognized Standards.***~~ Not provided in accordance with professionally recognized standards of health care. ~~*(4-5-00)*~~(10-1-03)T

~~***04***~~**d.** ~~***Prohibited Physician Referral.***~~ Provided as a result of a prohibited physician referral under 42 CFR Part 411, Subpart J. ~~*(4-5-00)*~~(10-1-03)T

0~~*5*~~2. Contrary To Rules Or Provider Agreement. ~~*Provided*~~ The Department may deny payment when services billed are contrary to ~~*these*~~ Department rules~~*, IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho,"*~~ or the provider agreement. ~~*(4-5-00)*~~(10-1-03)T

03. Failure To Provide Immediate Access To Records. The Department may deny payment when the provider does not allow immediate access to records as defined in Section 202 of these rules. (10-3-03)T

(BREAK IN CONTINUITY OF SECTIONS)

208. SUSPENSION OF PAYMENTS PENDING INVESTIGATION.
~~*In the event that t*~~The Department ~~*identifies*~~ may suspend payments in whole or part in a suspected case of fraud or abuse ~~*and the Department has reason to believe that payments made during the investigation may be difficult or impractical to recover, the Department may suspend or withhold payments on any pending or subsequently submitted claims while the provider continues to participate in the program*~~ pending investigation and conclusion of legal proceedings related to the provider's alleged fraud or abuse. ~~*(4-5-00)*~~(10-1-03)T

01. Basis For Suspension Of Payments. When the Department through reliable evidence suspects fraud or abuse, or when a provider fails to provide immediate access to records, Medicaid payments may be withheld or suspended. (10-1-03)T

02. Notice Of Suspension Of Payments. The Department may withhold payments without first notifying the provider of its intention to do so. The Department will send written notice according to 42 CFR 455-23(b) within five (5) days of taking such action. (10-1-03)T

03. Duration Of Suspension Of Payments. The withholding of payment actions under Section 208 of these rules will be temporary and will not continue after: (10-1-03)T

a. The Department or the prosecuting authorities determine there is insufficient evidence of fraud or willful misrepresentation by the provider; or (10-1-03)T

b. Legal proceedings related to the provider's alleged fraud or abuse are completed. (10-1-03)T

209. ~~*INTERIM*~~ PROVIDER AGREEMENT SUSPENSION.
In the event ~~*that*~~ the Department identifies a suspected case of fraud or abuse**.** ~~*and it determines that*~~ it may summarily suspend the provider agreement when such action is necessary to prevent or avoid immediate danger to the public health or safety.~~*, the Department may summarily suspend a provider or employee of a provider*~~ This provider agreement suspension temporarily bars the provider from participation in the Medicaid Program, pending investigation and Department action. ~~*Such a finding will be incorporated in the order.*~~ The Department will notify the provider ~~*shall be given notice but the order*~~ of the suspension. The suspension is effective ~~*when issued*~~ immediately upon written, electronic, or oral notification. ~~*(4-5-00)*~~(10-1-03)T

210. ~~*APPEAL OF IMMEDIATE ACTION*~~ (RESERVED).
~~*When payments have been suspended or withheld or the provider's agreement is suspended pending investigation, the Department shall provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal.*~~
~~*(4-5-00)*~~

(BREAK IN CONTINUITY OF SECTIONS)

212. CIVIL MONETARY PENALTIES.
~~*Pursuant to*~~ Under Section 56-209h, Idaho Code, the Department may assess civil monetary penalties against a provider, any officer, director, owner, and~~*/or*~~ managing employee for conduct identified in Subsections 211.01 through 211.09 of these rules. The amount of penalties ~~*shall*~~ may be up to one thousand dollars ($1,000) for each item or service improperly claimed, except that in the case of multiple penalties the Department may reduce the penalties to not less than twenty-five percent (25%) of the amount of each item or service improperly claimed if an amount can be readily determined. Each line item of a claim, or cost on a cost report is considered a separate claim. These penalties are intended to be remedial, at a minimum recovering costs of investigation and administrative review, and placing the costs associated with non-compliance on the offending provider. ~~*(4-5-00)*~~(10-1-03)T

213. MANDATORY EXCLUSIONS FROM THE MEDICAID PROGRAM.
The Department ~~*shall*~~ will exclude from the Medicaid Program any provider, entity or person that:

~~*(4-5-00)*~~(10-1-03)T

01. Conviction Of A Criminal Offense. Has been convicted of a criminal offense related to the delivery of an item or service under a federal or any state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program. (4-5-00)

02. Conviction Of A Criminal Offense Related To Patient Neglect Or Abuse. Has been convicted, under federal or state law, of a criminal offense related to the neglect or abuse of a patient, in connection with the delivery of a health care item or service, including any offense that the Department concludes entailed, or resulted in, neglect or abuse of patients. The conviction need not relate to a patient who is a program beneficiary. (4-5-00)

03. Other Exclusions. Is identified by ~~*HCFA*~~ the Centers for Medicare and Medicaid Services (CMS) as having been excluded by another state or the Office of Inspector General or any person ~~*HCFA*~~ CMS directs the Department to exclude. ~~*(4-5-00)*~~(10-1-03)T

214. TERMS OF MANDATORY EXCLUSIONS FROM THE MEDICAID PROGRAM.
~~*No m*~~Mandatory exclusions from the Medicaid Program imposed ~~*pursuant to*~~ under Subsections 213.01 and 213.02 of these rules, will be for not less than ten (10) years. The exclusion may exceed ten (10) years if aggravating factors are present. In the case of any mandatory exclusion of any person, if the individual has been convicted on two (2) or more previous occasions of one (1) or more offenses for which an exclusion may be effected under this section, the period of exclusion ~~*shall*~~ will be permanent. ~~*(4-5-00)*~~(10-1-03)T

215. PERMISSIVE EXCLUSIONS FROM THE MEDICAID PROGRAM.
The Department may exclude any person or entity from the Medicaid Program for a period of not less than one (1) year: ~~*(4-5-00)*~~(10-1-03)T

01. Endangerment Of Health Or Safety Of A Patient. Where there has been a finding by ~~*the Department or Quality Improvement Organization (QIO)*~~ a governmental agency against such person or entity of endangering the health or safety of a patient, or of patient abuse, neglect or exploitation. ~~*(4-1-03)T*~~(10-1-03)T

02. Failure To Disclose Or Make Available Records. That has failed or refused to disclose, ~~*or*~~ make available, or provide immediate access to the Department, or its authorized agent, or any licensing board, any records maintained by the provider or required of the provider to be maintained, which the Department deems relevant to determining the appropriateness of payment. ~~*(4-5-00)*~~(10-1-03)T

03. Other Exclusions. For any reason for which the Secretary of Health and Human Services, or his designee, could exclude an individual or entity. (3-30-01)

216. AGGRAVATING FACTORS.
For purposes of lengthening the period of mandatory exclusions and permissive exclusions from the Medicaid Program, the following factors may be considered. This is not intended to be an exhaustive list of factors which may be considered: ~~*(4-5-00)*~~(10-1-03)T

01. Financial Loss. The acts resulted in financial loss to the program of one thousand five hundred dollars ($1,500) or more. The entire amount of financial loss to such program will be considered, including any amounts resulting from similar acts not adjudicated, regardless of whether full or partial restitution has been made to the program. (4-5-00)

02. Time Acts Were Committed. The acts were committed over a period of one (1) year or more. (4-5-00)

03. Adverse Impact. The acts had a significant adverse physical, mental or financial impact on one (1) or more program recipients or other individuals. (4-5-00)

04. Length Of Sentence. The length of any sentence imposed by the court related to the same act. (4-5-00)

05. **Prior Record**. The excluded person has a prior criminal, civil or administrative sanction record. (4-5-00)

217. REFUSAL TO ENTER INTO AN AGREEMENT.
The Department may refuse to enter into a provider agreement if the provider: (10-1-03)T

01. **Convicted Of A Felony**. ~~h~~Has been convicted of a felony under federal or state law; or (10-1-03)T

02. **Committed An Offense Or Act Not In Best Interest Of Medicaid Recipients**. Has committed an offense or act which the Department determines is inconsistent with the best interests of ~~the~~ Medicaid recipients~~.~~; or (10-1-03)T

03. **Failed To Repay**. ~~h~~Has failed to repay the Department monies which had been previously determined to have been owed to the Department~~.~~; or ~~(4-5-00)~~(10-1-03)T

04. **Investigation Pending**. Has a pending investigation for program fraud or abuse; or (10-1-03)T

05. **Terminated Provider Agreement**. Was the managing employee, officer, or owner of an entity whose provider agreement was terminated under Section 211 of these rules. (10-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

224. APPEAL~~S~~ OF DEPARTMENT ACTION.
Any department action, may be appealed as a contested case ~~*pursuant to*~~ under the IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". ~~*Unless action is taken pursuant to Sections 208 or 209 of these rules, an appeal stays the action until the time to appeal the Department's final order has expired.*~~ ~~(4-5-00)~~(10-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0309

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), and 56-1004(l)(a), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Changes are being made to the proposed text in response to public comment received. New Subsection 146.13.e. was added to permit agencies to use a software system allowing personal assistants to register their start and stop times and maintain a list of services they provide by placing a telephone call to the agency system from the participant's home.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the October 1, 2003, Administrative Bulletin, Volume 03-10, pages 255 through 269.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Christine Baylis at (208) 364-1840.

DATED this 29th day of October, 2003.

Sherri Kovach
Program Supervisor
DHW - Administrative Procedures Section
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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-10, October 1, 2003, pages 255 through 269.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

Language That Has Been Deleted From The Original Proposed Rule Has Been Removed And New Language Is Shown In Italics

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THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0309-0309

SUBSECTION 146.13.e. (Partial Section)

146. PERSONAL CARE SERVICES (PCS).
Under Sections 39-5601 through 39-5607, Idaho Code, it is the intent of the Department to provide personal care services (PCS) to eligible participants in their own homes or personal residences to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage individual choice, and to maintain community integration. ( )

13. PCS Record Requirement - Participant In His Own Home. The PCS record must be maintained on all participants who receive PCS in their own homes. ( )

e. *Telephone Tracking System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsections 146.13.a. through 146.13.d. of this rule.* ( )

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0309

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), 56-1004(l)(a), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2003.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

Medicare has recently changed the Ambulatory Surgical Center (ACS) reimbursement methodology. Since this change is not compatible with Idaho Medicaid's automated system (AIM), the Department has opted to continue using the current reimbursement methodology. Since Idaho Medicaid no longer uses the same reimbursement methodology as Medicare, the reference in rule to Medicare's methodology was deleted.

The text in the Section of rule governing Personal Care Services (PCS) was deleted completely and the entire Section was reorganized and rewritten in plain language. Substantive changes include: clarification that eligible participants under age twenty-one (21) who meet the medical necessity criteria under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) may be eligible for up to twenty-four (24) hours a day of service delivery; and removal of the requirement that Personal Care Assistants be Certified Nursing Assistants (CNAs).

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. It is these additions and deletions to which the public comment should be addressed.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted prior to the publication of the proposed because rule changes involve clarification and reorganization of rule but contain no changes in the business process. Rule changes regarding PCS were made in consultation with Medicaid's Personal Assistance Oversight Committee.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Sheila Pugatch at (208) 364-1817 (regarding ACS) or Christine Baylis at (208) 364-1891 (regarding PCS).

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 22, 2003.

DATED this 18th day of August, 2003.

Sherri Kovach
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0309

121. AMBULATORY SURGICAL CENTER.
The Department ~~*will*~~ must provide Ambulatory Surgical Centers (ASC) services for eligible ~~*recipients*~~ participants. ~~*Reimbursement and covered medical procedures will be based on Medicare program coverage and payment principles.*~~ ~~*(9-30-84)*~~(____)

01. Facility Approval. The ASC must be surveyed by the Department's ~~*Licensure and Certification Section*~~ Bureau of Facility Standards as required by 42 CFR 416.25 through 416.49 and be approved by the U.S. Department of Health and Human Services for participation as a Medicare ASC provider. ~~*(9-30-84)*~~(____)

02. Provider Agreement. Following Medicare program approval, the Department may enter into a provider agreement with an ASC. No Medicaid payment may be made to any ASC in the absence of such an agreement. Grounds for cancellation of the provider agreement ~~*will*~~ include~~*, but not be limited to*~~: ~~*(9-30-84)*~~(____)

a. The loss of Medicare program approval~~*will constitute grounds for cancellation of the Department's provider agreement with the ASC.*~~; ~~*(9-30-84)*~~(____)

b. Identification of any condition which threatens the health or safety of patients by the Department's ~~*Licensure and Certification Section will constitute grounds for cancellation of the Department's provider agreement with the ASC*~~ Bureau of Facility Standards. ~~*(9-30-84)*~~(____)

03. Covered Surgical Procedures. Those surgical procedures identified by the Medicare program as appropriately and safely performed in an ASC will be reimbursed by the Department. In addition, the Department may add surgical procedures to the list~~*ing*~~ developed by the Medicare program as required by 42 CFR 416.65 if the procedures meet the criteria identified in 42 CFR 416.65 (a) and (b). ~~*(9-30-84)*~~(____)

a. The Department will provide a list of approved procedures to all participating ASCs. (9-30-84)

b. Such lists will be updated by the Department as new procedures are approved by the Medicare program. All participating ASCs will be notified by the Department of such changes. (9-30-84)

04. Payment Methodology. ASC services reimbursement is designed to pay for use of facilities and supplies necessary to safely care for the patient. Such services are reimbursed as follows: (9-30-84)

a. ASC facility service payments represent reimbursement for the costs of goods and services recognized by the Medicare program as described in 42 CFR, Part 416. Payment levels will be determined by the Department. Any surgical procedure covered by the Department as described in Subsection 121.03 of this rule, but which is not covered by Medicare will have a reimbursement rate established by the Department. ~~*(5-25-93)*~~(____)

b. ASC facility services ~~*will*~~ include~~*, but not be limited to,*~~ the following: ~~*(9-30-84)*~~(____)

i. Nursing, technician, and related services; ~~*and*~~ ~~*(9-30-84)*~~(____)

ii. Use of ASC facilities; ~~*and*~~ ~~*(9-30-84)*~~(____)

iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; ~~*and*~~ ~~*(9-30-84)*~~(____)

iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; ~~*and*~~ ~~*(9-30-84)*~~(____)

v. Administration, record-keeping and housekeeping items and services; and (9-30-84)

vi. Materials for anesthesia. (9-30-84)

c. ASC facility services do not include the following services: (9-30-84)

i. Physician services; ~~*and*~~ ~~*(9-30-84)*~~(____)

ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); ~~*and*~~ ~~*(9-30-84)*~~(____)

iii. Prosthetic and orthotic devices; ~~*and*~~ ~~*(9-30-84)*~~(____)

iv. Ambulance services; ~~*and*~~ ~~*(9-30-84)*~~(____)

v. Durable medical equipment for use in the patient's home; and (9-30-84)

vi. Any other service not specified in Subsection 121.04.b. of this rule. ~~*(12-31-91)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

~~***146. PERSONAL CARE SERVICES.***~~
~~*Pursuant to Sections 39-5601 through 39-5607, Idaho Code, it is the intention of the Department to provide personal care services to eligible participants in their personal residence in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to maintain community integration. For a participant to be eligible for personal care services, the Department must find that the participant requires personal care services due to a medical condition which impairs their physical or mental function or independence and must find the participant capable of being maintained safely and effectively in their own home or residence with personal care services.*~~ ~~*(3-30-01)*~~

~~***01. Care And Services Provided.***~~ ~~*(1-1-91)*~~

~~***a.*** *Medically oriented tasks having to do with a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home. Such services may include, but are not limited to:*~~ ~~*(5-3-03)*~~

~~*i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care, but excluding the irrigation or suctioning of any body cavities which require sterile procedures and the application of dressings, involving prescription, medication, and aseptic techniques; and*~~ ~~*(1-1-91)*~~

~~*ii. Assistance with bladder or bowel requirements which may include helping the participant to and from the bathroom or assisting the participant with bedpan routines, but excluding insertion or sterile irrigation of catheters; and*~~ ~~*(5-3-03)*~~

~~*iii. Assisting the participant with medications which are ordinarily self-administered, when ordered by a physician, but excluding the giving of injections or fluids into the veins, muscles, or skin, or administering of medicine; and*~~ ~~*(5-3-03)*~~

~~*iv. Assistance with food, nutrition, and diet activities to include the preparation of meals if incidental to medical need, as determined by a physician; and*~~ ~~*(7-15-83)*~~

~~*v. The continuation of active treatment training programs in the home setting to increase or maintain independence for the developmentally disabled participant.*~~ ~~*(5-3-03)*~~

~~*vi. Non-nasogastric gastrostomy tube feedings may be performed if authorized prior to*~~

~~*implementation by the Department's Regional Medicaid Unit and if the following requirements are met:* (2-19-92)~~

~~*(1) The task is non-complex and can be safely performed in the given participant care situation; and* (5-3-03)~~

~~*(2) A registered nurse has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, which is individualized for the participant's characteristics and needs; and* (5-3-03)~~

~~*(3) Persons to whom the procedure can be delegated are identified by name. The registered nurse must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing strengths and weaknesses of the person performing the procedure, and evaluate the performance of the procedure at least monthly; and* (2-19-92)~~

~~*(4) Any change in the participant's status or problem relative to the procedure must be reported immediately to the registered nurse; and* (5-3-03)~~

~~*(5) The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN, and must be readily available for review, preferably with the participant's record.* (5-3-03)~~

~~*(6) Medication previously received could be given by the personal care provider through the non-nasogastric tube unless contraindicated.* (2-19-92)~~

~~*vii. In addition to performing at least one (1) of the services listed in Subsections 146.01.a.i. through 146.01.a.vi., the provider may also perform the following services:* (2-19-92)~~

~~*(1) Such incidental housekeeping services essential to a participant's comfort and health, to include the changing of bed linens, rearranging furniture to enable the participant to move about more easily, laundry and room cleaning when incidental to the participant's treatment. Excluded are cleaning and laundry for any other occupant of the participant's residence; and* (5-3-03)~~

~~*(2) Accompanying the participant to clinics, physician office visits, or other trips which are reasonable for the purpose of obtaining medical diagnosis or treatment; and* (5-3-03)~~

~~*(3) Shopping for groceries or other household items required specifically for the health and maintenance of the participant.* (5-3-03)~~

~~***b.*** *Service Limitations. The maximum amount of personal care services available to an eligible participant is as follows:* (3-30-01)~~

~~*i. For adults receiving services under the State Medicaid Plan option, service delivery is limited to a maximum of sixteen (16) hours per week per participant.* (3-30-01)~~

~~*ii. For individuals under the age of eighteen (18) who meet medical necessity criteria under EPSDT, the eligible participant may receive up to twenty-four (24) hours per day of service delivery under the State Plan option.* (3-30-01)~~

~~***02. Place Of Service Delivery****. Personal Care Services (PCS) may be provided only in a participant's personal residence. The following living situations are specifically excluded as a personal residence for the purpose of these rules:* (3-30-01)~~

~~***a.*** *Certified nursing facilities (NF) or hospitals; and* (1-1-91)~~

~~***b.*** *Licensed Intermediate Care Facility for the Mentally Retarded; and* (7-15-83)~~

~~***c.*** *Intensive Treatment Facility For Children as described in IDAPA 16.06.01, "Rules Governing*~~

~~*Family and Children's Services," Section 620.* (4-5-00)~~

~~***d.*** *A home receiving payment for specialized foster care, professional foster care, or group foster care.* (4-5-00)~~

~~***03.*** ***Services Delivered Following A Written Plan****.* (7-15-83)~~

~~***a.*** *All PCS are provided based on a written plan of care which is the responsibility of the Personal Assistance Agency and the participant to prepare and is based on:* (3-30-01)~~

~~*i.* *The physician's or authorized provider's information including the orders; and* (3-30-01)~~

~~*ii.* *The nurse's or QMRP's assessment and observations of the participant; and* (5-3-03)~~

~~*iii.* *Information elicited from the participant.* (3-30-01)~~

~~***b.*** *The plan of care must include all aspects of personal care necessary to be performed by the PCS provider, including the amount, type, and frequency of such services.* (7-15-83)~~

~~***c.*** *The plan of care will be signed and approved by the physician or authorized provider, prior to the initiation of the services by the PCS provider.* (3-30-01)~~

~~***d.*** *The plan must be revised and updated based upon treatment results or a participant's changing profile of needs as necessary, but at least annually.* (5-3-03)~~

~~***04.*** ***Physician/Authorized Provider Supervision Of The Service****. All Personal Care Services are provided under the order of a licensed physician or authorized provider. The physician or authorized provider must:* (3-30-01)~~

~~***a.*** *Certify, in writing, that the services are medically necessary.* (3-30-01)~~

~~***b.*** *Order all services delivered by the PCS provider. Such orders are signed and dated by the physician or authorized provider and include, at a minimum, his signature and date of approval on the participant's plan of care.* (3-30-01)~~

~~***c.*** *Update the plan of care, including his signature and date of approval, as necessary, but at least annually.* (1-1-91)~~

~~***d.*** *Recommend institutional placement of the participant if he identifies that PCS, in combination with other community resources, are no longer sufficient to ensure the health or safety of the participant.* (3-30-01)~~

~~***05.*** ***Service Supervision****.* (1-1-91)~~

~~***a.*** *A registered nurse or a QMRP who is not functioning as the personal care provider may oversee the delivery of PCS. The need for such oversight will be identified by the RMU, and when received will include:* (3-30-01)~~

~~*i.* *In conjunction with the PAA and attending physician or authorized provider or the RMU or its contractor the development of a plan of care for the participant; and* (3-30-01)~~

~~*ii.* *Review of the treatment given by the personal care provider through a review of the participant's PCS record as maintained by the provider and on-site interviews with the participant at least every ninety (90) days; and* (5-3-03)~~

~~*iii.* *Reevaluation of the plan of care as necessary and obtaining physician or authorized provider approval on all changes. The entire plan is reviewed at least annually; and* (3-30-01)~~

~~*iv. Immediate notification of the physician or authorized provider of any significant changes in the participant's physical condition or response to the service delivery; and (3-30-01)*~~

~~*v. Provides an on-site visit to the participant to evaluate changes of condition when requested by the PCS provider, QMRP supervisor, PAA, case manager, or participant. (3-30-01)*~~

~~***b.** In addition to, or instead of the supervisory visit by the registered nurse, all clients who are developmentally disabled, other than those with only a physical disability, as determined by the Regional Medicaid Unit may receive oversight of service delivery by a Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR 483.430. Such oversight will include: (3-30-01)*~~

~~*i. In conjunction with the attending physician or authorized provider, the QMRP may assist in the development of the plan of care for the participant for those aspects of active treatment which are provided in the home by the PCS attendant. (3-30-01)*~~

~~*ii. Review of the care and/or training given by the personal care provider through a review of the participant's PCS record as maintained by the provider, and on-site interviews with the participant at least every ninety (90) days. (5-3-03)*~~

~~*iii. Reevaluation of the plan of care as necessary, but at least annually. (1-1-91)*~~

~~*iv. An on-site visit to the participant to evaluate any change of condition when requested by the PCS provider, PAA, nurse supervisor, case manager, or participant. (3-30-01)*~~

~~***06. PCS Provider Qualifications**. (1-1-91)*~~

~~***a.** Persons providing PCS: Individuals may provide PCS either as personal assistance agency employees, or employees of record of a personal assistance agency functioning as a fiscal intermediary (FI), if they have at least one (1) of the following qualifications: (3-30-01)*~~

~~*i. Registered Nurse, RN: A person currently licensed by the Idaho State Board of Nursing as a registered nurse; or (7-15-83)*~~

~~*ii. Licensed Practical Nurse, L.P.N.: A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (7-15-83)*~~

~~*iii. Nursing Assistant: All nursing assistants who provide PCS to participants must appear on the Idaho State Board of Nursing's registry of certified nurse aides (CNA) or other training program approved by the Department. An individual who has completed a certified nurse aide training program may be granted provisional provider status for up to ninety (90) days by the Department to allow for the completion of competency testing and registry. (5-3-03)*~~

~~*iv. Specially Qualified Assistant. A person who has documented training to meet the needs of a specific individual by a personal assistance agency, the participant, or the participant's family. Such training must be provided before services are delivered or reimbursed by Medicaid. (3-30-01)*~~

~~***b.** All persons who care for participants with a developmental disability other than those with only physical disabilities as identified by the Department's RMU will, in addition to the completion of the requirements of Subsection 146.06.a.iii., have completed one (1) of the Department approved developmental disabilities training courses, or have experience in working directly providing services to people with developmental disabilities. Providers who are qualified as QMRPs will be exempted from the Department approved developmental disabilities training course. Each region may grant temporary approval to an individual who meets all qualifications except for the required developmental disabilities training course or experience to become a PCS provider to a participant with developmental disablility if all of the following conditions are met: (3-30-01)*~~

~~*i. The RMU has verified that there are no qualified providers reasonably available to provide services to the participant requesting services; and (5-3-03)*~~

~~*ii. The provider must be enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary status; and* (7-1-94)~~

~~*iii. The supervising QMRP makes monthly visits until the provider graduates from the training program.* (7-1-94)~~

~~***c.*** *Personal Assistance Agency providers must submit to the Department documentation of their worker's compensation and professional liability insurance coverage. In the case of worker's compensation, agencies will direct their sureties to provide a certificate of insurance to the Department. Termination of either type of insurance by the provider will be cause for termination of Provider status by the Department. Personal Assistance Agency providers will keep copies of employee health screens in their files for review by the Department as necessary. Providers' employees of fact or record will subject themselves to a criminal history check conducted by the Department. If no criminal history is indicated on the Self-Declaration form, individuals may be authorized by the Region to provide services on a provisional basis while awaiting the results of the fingerprinting process. Such authorization may be provided after the participant's safety is assured by the responsible Region.* (5-3-03)~~

~~***d.*** *Individuals providing supervision to PCS attendants.* (1-1-91)~~

~~*i. RN supervisors will have a current Idaho professional nursing license (RN).* (1-1-91)~~

~~*ii. Qualified Mental Retardation Professional (QMRP) supervisors will be qualified by education and training as required in 42 CFR 483.430.* (1-1-91)~~

~~***e.*** *Provider agency. A personal assistance agency which has a signed provider agreement with the Department and is capable of and responsible for all of the following:* (3-30-01)~~

~~*i. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal care attendants and the assurance of quality service provided by the personal care attendants; and* (1-1-91)~~

~~*ii. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; and* (8-5-91)~~

~~*iii. Maintenance of liability insurance coverage; and* (1-1-91)~~

~~*iv. Provision of a licensed professional nurse (RN) or, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a participant's care; and* (3-30-01)~~

~~*v. Assignment of a qualified personal care attendant(s) to eligible participants after consultation with and approval of such participants; and* (3-30-01)~~

~~*vi. Assure that all PCS attendants meet the qualifications in Subsection 146.06.a.; and* (12-31-91)~~

~~*vii. Billing Medicaid for services approved and authorized by the RMU; and* (1-1-91)~~

~~*viii. Make referrals for PCS-eligible participants for case management services when a need for such services is identified; and* (3-30-01)~~

~~*ix. Conduct such criminal background checks and health screens on new and existing employees as required in Subsection 146.10 and 146.11.* (12-31-91)~~

~~***f.*** *Fiscal intermediaries services. Independent living services provided by an entity which has a signed Personal Assistance provider agency agreement with the Department and meets the requirements of Subsection 669.03.* (3-30-01)~~

~~***g.*** *When care is provided in the provider's home, acquire the appropriate level of child foster or day care licensure or certification. The provider must be licensed as defined in Section 39-1213, Idaho Code, for care of*~~

~~*individuals under eighteen (18) years of age. Noncompliance with the above standards will be cause for termination of the provider's provider agreement.* (3-30-01)~~

~~***h.*** *A PCS attendant cannot be a relative of any participant to whom the provider is supplying services.* (3-30-01)~~

~~*i.* *For the purposes of this subsection, a relative is defined as a spouse or a parent of a minor child.* (1-1-91)~~

~~*ii.* *Nothing in this subsection shall be construed to prohibit a relative from providing PCS where Medicaid is not the payment source for such services.* (1-1-91)~~

~~***07.*** ***Participant Eligibility Determination****. An eligible participant may qualify for PCS coverage under the Idaho State Medicaid Plan. The participant must be financially eligible for MA as described in Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)". The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, in the assessment of the RMU, the participant could be maintained in their own home or residence and receive safe and effective services through the Personal Care Service Program. Eligible participants receiving PCS under the Idaho State Plan must have a completed UAI, medical justification, physician's or authorized provider's orders, and plan of care for such services. All services will be authorized by the RMU prior to payment for the amount and duration of services based on this information.* (5-3-03)~~

~~***08.*** ***Case Redetermination****.* (12-31-91)~~

~~***a.*** *Financial redetermination will be conducted pursuant to Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)". Medical redetermination will be made at least annually by the RMU, or sooner at the request of the participant, the eligibility examiner, PAA, personal care provider, the supervising registered nurse, QMRP, the physician, or authorized provider. The sections cited implement and are in accordance with Idaho's approved state plan with the exception of deeming of income provisions.* (5-3-03)~~

~~***b.*** *The redetermination process will assess the following factors:* (7-15-83)~~

~~*i.* *The participant's continued need for Personal Care Services; and* (3-30-01)~~

~~*ii.* *Discharge from Personal Care Services; and* (3-30-01)~~

~~*iii.* *Referral of the participant from Personal Care Services to a nursing facility.* (5-3-03)~~

~~***09.*** ***Criminal History Check****. All personal care providers (case managers, RN supervisors, QMRP supervisors and personal care attendants) shall participate in a criminal history check as required by Section 39-5604, Idaho Code. The criminal history check will be conducted in accordance with IDAPA 16, Title 05, Chapter 06, "Rules Governing Mandatory Criminal History Checks".* (10-1-94)~~

~~***10.*** ***Health Screen****. The Department will require that a health questionnaire be completed by each personal assistance agency employee who serves as a personal care attendant. Personal assistance agencies will retain this in their personnel file. If the applicant indicates on the questionnaire that he has a medical problem, the individual will be required to submit a statement from a physician or authorized provider that his medical condition would not prevent him from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health screen is cause for termination of employment for agency employees.* (3-30-01)~~

~~***11.*** ***PCS Record****. Three (3) types of record information will be maintained on all participants receiving PCS and are considered to be the PCS record.* (3-30-01)~~

~~***a.*** *Personal Care Provider Information. Each provider will maintain a written documentation of each visit made to a participant, and will record at a minimum the following information:* (5-3-03)~~

~~*i. Date and time of visit; and* (1-1-91)~~

~~*ii. Services provided during the visit; and* (1-1-91)~~

~~*iii. A statement of the participant's response to the service, including any changes noted in the participant's condition; and* (3-30-01)~~

~~*iv. Length of visit and unless it is determined by the RMU that the participant is unable to do so, the record of service delivery should be verified by the participant as evidenced by their signature on the service record; and* (3-30-01)~~

~~*v. Any changes in the treatment plan authorized by the referring physician, authorized provider or supervising registered nurse or QMRP as the result of changes in the participant's condition.* (3-30-01)~~

~~*vi. A copy of the information contained in Subsections 146.13.a.i. through 146.13.a.v., will be maintained in the participant's home unless authorized to be kept elsewhere by the RMU. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services.* (3-30-01)~~

~~***b.*** *Plan of Care. The plan of care which is initiated by the attending physician or authorized provider, developed by the supervising RN or QMRP, must specify diagnosis, general treatment and the Personal Care Services which are required by the participant. The plan will contain all elements required by Subsection 146.03 and a copy of the most current plan of care will be maintained in the participant's home and will be available to the PCS Attendant, Supervising RN, QMRP and, if applicable, the case manager.* (3-30-01)~~

~~***c.*** *Oversight Information. In addition to the plan of care, at least every ninety (90) days the Supervising RN or the QMRP may verify, in writing, that the services provided were consistent with the treatment plan. Any changes in the treatment plan will be documented and include the signature of the Supervising RN or QMRP.* (5-3-03)~~

~~***12. Provider Responsibility For Notification****. It is the responsibility of the PAA to notify either the RMU and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the PAA record.* (5-3-03)~~

~~***13. Records Maintenance****. In order to provide continuity of services, when a participant is transferred among providers, all of the foregoing participant's records will be delivered to and held by the field office of the Department until a replacement provider assumes the case. PAAs will be responsible to retain their participants' records for five (5) years following the date of service.* (5-3-03)~~

~~***14. Provider Coverage Limitations****.* (4-5-00)~~

~~***a.*** *In congregate living situations, payment is limited to one (1) claim per provider act. In no case may more time be billed than was actually spent by the provider in service delivery.* (4-5-00)~~

~~***b.*** *No provider may serve more than two (2) children who are authorized for eight (8) or more hours of care per day.* (3-30-01)~~

~~***15. Community Awareness Program****. The Department will establish and maintain a community awareness program that will educate Idaho citizens regarding the purpose and function of all long-term care alternatives including, but not limited to, personal assistance services and individual participant rights. This program will be developed in cooperation with other state agencies including, but not limited to, the Commission On Aging and the State Independent Living Council.* (3-30-01)~~

146. PERSONAL CARE SERVICES (PCS).

Under Sections 39-5601 through 39-5607, Idaho Code, it is the intent of the Department to provide personal care services (PCS) to eligible participants in their own homes or personal residences to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage

individual choice, and to maintain community integration. ( )

01. **Personal Assistance Agency (PAA)**. A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-Personal Assistance Agencies, Aged and Disabled Waiver Provider Agreement with the Department. The PAA agrees to comply with all conditions within the agreements. A Personal Assistance Agency may also provide fiscal intermediary services as defined in Section 669 of these rules. Each Personal Assistance Agency must direct, control, and monitor the work of each of its personal assistants. A Personal Assistance Agency must be capable of and is responsible for all of the following, no matter how the PAA is organized or the form of the business entity it has chosen: ( )

a. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; ( )

b. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; ( )

c. Maintenance of liability insurance coverage. Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the provider's provider agreement; ( )

d. Provision of a licensed professional nurse (RN) or, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a participant's care; ( )

e. Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; ( )

f. Assuring that all personal assistants meet the qualifications in Subsection 146.09 of these rules; ( )

g. Billing Medicaid for services approved and authorized by the RMS; ( )

h. Making referrals for PCS-eligible participants for case management services when a need for these services is identified; and ( )

i. Assuring that it provides quality services in compliance with applicable rules. Results of quality assurance reviews conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. The provider must respond within forty-five (45) days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. ( )

02. **Participant Eligibility Determination**. The participant's eligibility for PCS must be redetermined at least annually under Subsection 146.10 of these rules. ( )

a. Financial Eligibility. The participant must be financially eligible for Medical Assistance (MA) under IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families and Children" or 16.03.05, "Rules Governing Eligiblility for Aid to the Aged, Blind and Disabled". ( )

b. Medical Eligibility. All PCS must be provided under the order of a licensed physician or authorized provider. The physician or authorized provider must: ( )

i. Certify in writing that the services are medically necessary; ( )

ii. Recommend institutional placement of the participant if he identifies that PCS, in combination with other community resources or services offered through the Home and Community Based Waivers, are no longer sufficient to ensure the health or safety of the participant. ( )

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

i. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS; ( )

ii. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed. A UAI is not to be completed for a child participant; ( )

iii. The RMS reviews the documentation for medical necessity; ( )

iv. The participant has a plan of care; and ( )

v. Services are ordered by a physician or authorized provider. ( )

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

03. Service Limitations. ( )

a. Adults who receive PCS under the State Medicaid Plan option are limited to a maximum of sixteen (16) hours per week per participant. ( )

b. Children who meet the necessity criteria for EPSDT services under Section 536 of these rules may receive up to twenty-four (24) hours of PCS per day per child through the month of their twenty-first birthday.( )

04. Medical Care And Services Provided. PCS services include medically-oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence. The provider must deliver at least one (1) of the following services: ( )

a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; ( )

b. Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines; ( )

c. Assisting the participant with physician-ordered medications that are ordinarily self-administered, such as opening the packaging or reminding the participant to take medications; ( )

d. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; ( )

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

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

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

ii. A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs; ( )

iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly; ( )

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN; ( )

v. The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN and must be readily available for review, preferably with the participant's record; and ( )

vi. Routine medication may be given by the personal assistant through the non-nasogastric tube if authorized by the supervising RN. ( )

g. The provider is excluded from delivering the following services: ( )

i. Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; ( )

ii. Insertion or sterile irrigation of catheters; ( )

iii. Injecting fluids into the veins, muscles or skin; and ( )

iv. Administering medication. ( )

05. Non-Medical Care And Services Provided. PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed in Subsections 146.04.a. through 146.04.f. of this rule, the provider may also perform the following services: ( )

a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded. ( )

b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment. ( )

c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant. ( )

06. Place Of Service Delivery. PCS may be provided only in the participant's own home or personal residence. The participant's personal residence may be a Certified Family Home (CFH) or a licensed Residential or Assisted Living Facility. The following living situations are specifically excluded as a personal residence: ( )

a. Certified nursing facilities (NFs) or hospitals. ( )

b. Licensed Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). ( )

c. A home that receives payment for specialized foster care, professional foster care or group foster care, as described in IDAPA 16.06.01, "Rules Governing Family and Children's Services". ( )

07. Service Delivery Based On Plan Of Care Or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential or Assisted Living Facilities are described in IDAPA 16.03.22, "Rules for Licensed Residential or Assisted Living Facilities in Idaho". The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes". The Personal Assistance Agency and the participant who lives in his own home are responsible to prepare the plan of care. ( )

a. The plan of care for participants who live in their own homes is based on: ( )

i. The physician's or authorized provider's information, including their orders for service; ( )

ii. The results of the UAI for adults, the Personal Assistance Agency's assessment for children and, if applicable, the QMRP's assessment and observations of the participant; and ( )

iii. Information obtained from the participant. ( )

b. The plan of care must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type and frequency of necessary services. ( )

c. The plan of care must be revised and updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. ( )

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

a. Oversight must include all of the following: ( )

i. Assistance in the development of the written plan of care; ( )

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

iii. Reevaluation of the plan of care as necessary; and ( )

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

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

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

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

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

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

09. **Provider Qualifications For Personal Assistants**. ( )

a. All personal assistants must have at least one (1) of the following qualifications: ( )

i. Licensed Professional Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a licensed professional nurse; ( )

ii. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or ( )

iii. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. The RMS may require a certified nursing assistant (CNA) if, in their professional judgment, the participant's medical

condition warrants a CNA. ( )

b. In the case where care is provided in the participant's own home, and the participant has a developmental disability that is not physical only and requires more than physical assistance, all those who provide care must have completed one (1) of the Department-approved developmental disabilities training courses, or have experience providing direct services to people with developmental disabilities. RMS determines whether developmental disability training is required. Providers who are qualified as QMRPs are exempted from the Department-approved developmental disabilities training course. ( )

c. In order to serve a participant with a developmental disability, a region may temporarily approve a PCS provider who meets all qualifications except for the required training course or experience, if all the following conditions are met: ( )

i. The RMS verifies that there are no other qualified providers available; ( )

ii. The provider is enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary provider status; and ( )

iii. The supervising QMRP makes monthly visits until the provider graduates from the training program. ( )

d. If PCS is paid for by Medicaid, a PCS service provider cannot be the spouse of any participant or be the parent of a participant if the participant is a minor child. ( )

e. When care for a child is delivered in the provider's home, the provider must be licensed or certified for the appropriate level of child foster care or day care. The provider must be licensed for care of individuals under age eighteen (18), as defined in Section 39-1213, Idaho Code. Noncompliance with these standards is cause for termination of the provider's provider agreement. ( )

f. When care for an adult is provided in a home owned or leased by the provider, the provider must be certified as a Certified Family Home under IDAPA 16.03.19, "Rules Governing Certified Family Homes". ( )

10. Annual Eligibility Redetermination. ( )

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

b. The medical redetermination must assess the following factors: ( )

i. The participant's continued need for PCS; ( )

ii. Discharge from PCS; and ( )

iii. Referral of the participant from PCS to a nursing facility. ( )

11. Criminal History Check. All PCS providers, including service coordinators, RN supervisors, QMRP supervisors and personal assistants, must participate in a criminal history check as required by Section 39-5604, Idaho Code. The criminal history check must be conducted in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks". ( )

12. Health Screen. Each Personal Assistance Agency employee who serves as a personal assistant must complete a health questionnaire. Personal Assistance Agencies must retain the health questionnaire in their personnel files. If the personal assistant indicates on the questionnaire that he has a medical problem, he is required to

submit a statement from a physician or authorized provider that his medical condition does not prevent him from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health questionnaire may be cause for termination of employment for the personal assistant and would disqualify the employee to provide services to Medicaid participants. ( )

13. **PCS Record Requirement - Participant In His Own Home**. The PCS record must be maintained on all participants who receive PCS in their own homes. ( )

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

i. Date and time of visit; ( )

ii. Length of visit; ( )

iii. Services provided during the visit; and ( )

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

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

c. Plan of Care. The plan of care must contain all the elements required under Subsection 146.07 of these rules. ( )

d. A copy of the information required in Subsections 146.13.a. through 146.13.d. of this rule must be maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. ( )

14. **Participant In A Residential Or Assisted Living Facility**. The PCS record requirements for participants in Residential or Assisted Living Facilities are described in IDAPA 16.03.22, "Rules for Licensed Residential or Assisted Living Facilities in Idaho". ( )

15. **Participant In A Certified Family Home**. The PCs record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes". ( )

16. **Provider Responsibility For Notification**. The Personal Assistance Agency is responsible to notify the RMS and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. ( )

17. **Provider Coverage Limitations**. ( )

a. The provider must not bill for more time than was actually spent in service delivery. ( )

b. No provider home, regardless of the number of providers in the home, may serve more than two (2) children who are authorized for eight (8) or more hours of PCS per day. ( )

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0310

NOTICE OF RULEMAKING

PENDING RULE AND AMENDMENT TO TEMPORARY RULE

EFFECTIVE DATE: The effective dates of the amendments to the temporary rule are January 1, 2003, and November 1, 2003. This pending rule has been adopted by the agency and is now pending review by the 2004 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended, or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended, or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), and 56-1004(l)(a), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the existing temporary rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change. In response to comments received from the public and Department staff, minor changes have been made for clarification.

Pursuant to Section 67-5228, Idaho Code, typographical, transcriptional, and/or clerical corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes that differ from the proposed text are printed in this bulletin. The original text of the proposed rules was published in the October 1, 2003, Administrative Bulletin, Volume 03-10, pages 275 through 286.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Mary Wells at (208) 364-1840.

DATED this 19th day of November, 2003.

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IDAPA 16, TITLE 03, CHAPTER 09

RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

There are substantive changes from the proposed rule text.

Only those sections that have changed from the original proposed text are printed in this Bulletin following this notice.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 03-10, October 1, 2003, pages 275 through 286.

This rule has been adopted as a pending rule by the Agency and is now pending review and approval by the 2004 Idaho State Legislature as a final rule.

THE FOLLOWING IS THE AMENDED TEXT OF DOCKET NO. 16-0309-0310

SECTION 560 (Partial Section)

560. SCHOOL-BASED HEALTH-RELATED SERVICES PROVIDED BY IDAHO PUBLIC SCHOOL DISTRICTS AND THE IDAHO INFANT TODDLER PROGRAM UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA).
The Department will pay school districts, including charter schools and the Idaho Infant Toddler Program, for covered rehabilitative and health-related services under IDAPA 16.03.09, "Rules Governing the Medical Assistance Program". Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code, that have entered into a provider agreement with the Department. Under the Individuals with Disabilities Act (IDEA), Part C, the Infant Toddler Program serves children from birth until their third birthday or until the beginning of the school year of their third birthday. Idaho public school districts provide services to students three (3) years of age through the semester of their twenty-first birthday. For children who are enrolled in the Infant Toddler Program, these rules apply only to services delivered by the Department or services delivered under a contractual agreement with the Idaho Infant Toddler Program, for which the Department will bill and reimburse the service provider. ~~*(1-1-03)T*~~(1-1-03)T

SUBSECTION 561.04.b. and 561.05 (Partial Section)

561. MEDICAID ELIGIBILITY.
To be eligible for medical assistance reimbursement for covered services, school districts and the Infant Toddler Program must ensure the student is: (1-1-03)T

04. Educational Disability. (1-1-03)T

b. A child from birth to three (3) years of age, who has been identified as needing early intervention services due to a developmental delay or disability ~~*under*~~ or who meets the eligibility criteria of the Idaho Infant Toddler Program; ~~*(1-1-03)T*~~(1-1-03)T

05. Individualized Education Program (IEP) And Other Service Plans. Covered by a current Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), or Services Plan (SP), developed within the previous three hundred sixty-five (365) days which indicates the need for one (1) or more medically necessary health-related services and lists all the Medicaid reimbursable services for which the school district or agency is requesting reimbursement; and ~~*(1-1-03)T*~~(1-1-03)T

SUBSECTION 562.02 (Partial Section)

562. SERVICE-SPECIFIC ELIGIBILITY.
In addition to meeting the Medicaid eligibility requirements in Section 561 of these rules, Psychosocial Rehabilitation (PSR), Developmental Therapy, and Intensive Behavioral Intervention (IBI) have additional eligibility requirements. (1-1-03)T

02. Developmental Therapy. To be eligible for developmental therapy, the student must meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the Developmental Disabilities Determination Checklist available online at: http://www.sde.state.id.us/SpecialEd/medicaid. ~~*(1-1-03)T*~~(1-1-03)T

SUBSECTION 563.04 (Partial Section)

563. EVALUATION AND DIAGNOSTIC SERVICES.
Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (1-1-03)T

04. Recommend Interventions. Include ~~*R*~~recommended interventions to address each need. ~~*(4-5-00)*~~(1-1-03)T

SECTION 564 (Partial Section)

564. REIMBURSABLE SERVICES.
School districts and Infant Toddler programs may bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals for the Medicaid services for which the school district, ~~*or other educational agency*~~ charter school, or Infant Toddler Program is seeking reimbursement. ~~*(1-1-03)T*~~(1-1-03)T

04. Medical Equipment And Supplies. Medical equipment and supplies that are covered by Medicaid must be ordered by a physician and prior authorized, based on medical necessity, in order to be billed. Authorized items must be used at school or for the Infant Toddler Program at the location where the service is provided. Equipment that is too large or unsanitary to transport from home to school may be covered if prior authorized. The equipment and supplies must be used for the student's exclusive use and transfer with the student if the student changes schools. Equipment no longer usable by the student, may be donated to the school or Infant Toddler Program by the student. ~~*(1-1-03)T*~~(1-1-03)T

SUBSECTION 569.03, 569.08, and 569.11.f. (Partial Section)

569. PROVIDER STAFF QUALIFICATIONS.
Medicaid will only reimburse for services provided by qualified staff. See Section 574 of these rules for the limitations and requirements for paraprofessional service providers. The following are the minimum qualifications for professional providers of covered services: (1-1-03)T

03. Developmental Therapy And Evaluation. Must be provided by or under the direction of a developmental specialist, as set forth in IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies". Certified special education teachers are not required to take the Department-approved course indicated in IDAPA 16.04.11 and be certified as a Developmental Specialist, Child. Only those school personnel who are working under a

Letter of Authorization or as a Specialty Consultant must meet the certification requirements in IDAPA 16.04.11. ~~*(1-1-03)T*~~(1-1-03)T

08. Physical Therapy And Evaluation. Must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. ~~*(1-1-03)T*~~(1-1-03)T

11. Psychosocial Rehabilitation. Must be provided by a: (11-1-03)T

f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; ~~*(11-1-03)T*~~(11-1-03)T

SUBSECTION 575.04 (Partial Section)

575. PAYMENT FOR SERVICES.
Payment for health-related services provided by school districts and Infant Toddler programs must be in accordance with rates established by the Department. (1-1-03)T

04. Contracted Providers. ~~*A contracted provider of the school program may not submit a separate claim to Medicaid as the performing provider for services provided under the school-based program and codes. A*~~ When a school program contracts with a service provider to deliver services identified on the plan, the school program must bill Medicaid for the contracted services. The contracted service provider ~~*of a school program must accept the payment from Medicaid as payment in full and*~~ must not bill ~~*a*~~ Medicaid or the Medicaid participant ~~*for any portion of any charges*~~. ~~*(1-1-03)T*~~(1-1-03)T

SUBSECTIONS 577.02 and 577.04.b. (Partial Section)

577. REQUIREMENTS FOR COOPERATION WITH AND NOTIFICATION OF PARENTS AND AGENCIES.
Each school district or Infant Toddler Program billing for Medicaid services must act in cooperation with students' parents and with community and state agencies and professionals who provide like Medicaid services to the student. (1-1-03)T

02. Notification To Primary Care Physician. School districts and Infant Toddler programs must request the name of the student's primary care physician from the parent or guardian so the school program can share health-related information with the physician with written consent from the parent or guardian. The following information must be sent to the student's primary care physician: ~~*(1-1-03)T*~~(1-1-03)T

04. Parental Consent To Release Information. School districts and Infant Toddler programs: (1-1-03)T

b. Must document the parent's denial of consent if the parent refuses to consent to the release of information regarding education-related services.~~*; and*~~ including release of the name of the student's primary care physician. ~~*(1-1-03)T*~~(1-1-03)T

2004 - Health and Welfare Senate Vol 1 Pending Rule (Yellow)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0310

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: These temporary rules have effective dates of January 1, 2003 and November 1, 2003.

AUTHORITY: In compliance with Section 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules and initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-1003(l), and 56-1004(l)(a), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, public hearings(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2003.

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 non-technical explanation of the substance and purpose of the proposed rule making:

The purpose of these rule changes is to reduce the administrative duplication that occurs between the Medicaid program and the Department of Education and to increase health care access, in the most cost-effective manner, for Medicaid-eligible children receiving services in schools. These rule changes build on existing educational requirements and rely on existing controls for managing service utilization.

These rule changes exempt schools from the lifetime cap for Intensive Behavioral Intervention (IBI) services, the requirement that IBI services be prior authorized, the referral requirements associated with the Healthy Connections program, and other limitations on services. In addition, changes eliminate references to the Procedural Guidelines given to school districts, but integrate the content of these guidelines into the rule. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) was eliminated as a school-based service. Finally, two (2) new sections of rules were added: one describes the eligibility requirements for Psychosocial Rehabilitation (PSR), developmental therapy, and IBI services; the other describes individual and group PSR services. Clarifications and corrections were made throughout the rule.

The proposed rule text is in legislative format. Language the agency proposes to add is underlined. Language the agency proposes to delete is struck out. Public comment should be addressed to these additions and deletions.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code, and are necessary in order to protect the public health, safety and welfare, and confer a benefit.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, informal negotiated rulemaking was conducted over the last two (2) years by the Department of Health and Welfare through meetings of the School-based Services Task Force comprised of representatives from the Department of Education, Idaho's independent school districts and school district superintendents, special education administrators, Idaho Parents Unlimited (IPUL), and Department staff from the divisions of Medicaid and Family and Community Services (FACS).

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Mary Wells at (208) 364-1955.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 22, 2003.

DATED this 15th day of August, 2003.

Sherri Kovach
Administrative Procedures Coordinator
DHW – Administrative Procedures Section
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0310

011. INCORPORATION BY REFERENCE.
The following ~~is~~ are incorporated by reference in this chapter of rules: ~~(3-15-02)~~(1-1-03)T

01. Travel Policies And Procedures Of The Idaho State Board Of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000~~.~~, ~~(3-15-02)~~

~~**02. Availability.** The "Idaho Travel Policies and Procedures of the Idaho State Board of Examiners," can be found~~ is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.state.id.us. ~~(3-15-02)~~(1-1-03)T

0~~3~~2. Medicare Region D Durable Medical Equipment Regional Carrier DMERC Supplier Manual April 2001. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (3-15-02)

03. Idaho Special Education Manual, September 2001. The full text of the "Idaho Special Education Manual, September 2001" is available on the Internet at http://www.sde.state.id.us/SpecialEd/ manual/sped.asp. A copy is also available at the Idaho Department of Education, 650 West State Street, P.O. Box 83720, Boise, Idaho 83720-0027. (1-1-03)T

04. Idaho Infant Toddler Program Implementation Manual (Revised September 1999). The full text of the "Idaho Infant Toddler Program Implementation Manual," revised September 1999, is available at the Department of Health and Welfare at 450 West State Street, P.O. Box 83720, Boise, Idaho 83720-0036. (1-1-03)T

05. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. A copy is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho 83702. (1-1-03)T

06. DSM-IV-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (11-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

560. SCHOOL-BASED HEALTH-RELATED SERVICES PROVIDED BY IDAHO PUBLIC SCHOOL DISTRICTS ~~*OR OTHER PUBLIC EDUCATIONAL AGENCIES (*~~ AND THE IDAHO INFANT TODDLER PROGRAM UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA).
The Department will pay school districts, including charter schools and ~~*other public educational agencies*~~ the Idaho Infant Toddler Program, for covered rehabilitative and health-related services ~~*pursuant to*~~ under IDAPA 16.03.09, "Rules Governing the Medical Assistance Program;". Services includ~~*ing*~~e medical or remedial services provided by school districts or other cooperative service agencies, ~~(~~as defined in Section 33-317, Idaho Code~~)~~, ~~*which*~~ that have entered into a provider agreement with the Department. ~~*Medicaid payment is also contingent upon school districts following current procedural guidelines established by the Department of Health and Welfare, Division of Medicaid for health related services provided by school districts and other public educational agencies.*~~ Under the Individuals with Disabilities Act (IDEA), the Infant Toddler Program serves children from birth until their third birthday or until the beginning of the school year of their third birthday. Idaho public school districts provide services to students three (3) years of age through the semester of their twenty-first birthday. For children who are enrolled in the Infant Toddler Program, these rules apply only to services delivered by the Department or services delivered under a contractual agreement with the Idaho Infant Toddler Program, for which the Department will bill and reimburse the service provider. ~~*(5-3-03)*~~(1-1-03)T

561. ~~*RECIPIENT*~~ MEDICAID ELIGIBILITY.
To be eligible for medical assistance reimbursement for covered services, ~~*a*~~ school districts and the Infant Toddler Program must ensure the student ~~*shall*~~ is: ~~*(4-5-00)*~~(1-1-03)T

01. ~~***Education Disability****. Be identified as having an educational disability pursuant to IDAPA 08.02.03, "Rules Governing Thoroughness," Subsection 100.09.b., Department of Education standards for the education of disabled students or, for children birth to three (3) years of age, being identified as needing early intervention services due to a developmental delay or disability in accordance with the eligibility criteria of the Idaho Infant Toddler Program; and*~~ **Medicaid Eligible**. Eligible for Medicaid and the service for which the school district or Infant Toddler Program is seeking reimbursement; ~~*(4-5-00)*~~(1-1-03)T

02. ~~***Individualized Education Program****. Have a current Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) which indicates the need for one (1) or more medically necessary health related services; and lists all Medicaid reimbursable services for which the school district or agency is requesting reimbursement; and*~~ **School Enrollment**. Enrolled in an Idaho school district or the Idaho Infant Toddler Program; ~~*(4-5-00)*~~(1-1-03)T

03. Age. ~~*Be less than t*~~Twenty-~~*two*~~ one (2~~*2*~~1) years of age~~*;*~~ or younger and the semester in which his twenty-first birthday falls is not finished; ~~*(4-5-00)*~~(1-1-03)T

04. ~~***Medicaid Eligible****. Be eligible for Medicaid and the service for which the school district is seeking reimbursement;*~~ **Educational Disability**. ~~*(4-5-00)*~~(1-1-03)T

a. Identified as having an educational disability under the Department of Education standards in IDAPA 08.02.03, "Rules Governing Thoroughness"; or (1-1-03)T

b. A child from birth to three (3) years of age, who has been identified as needing early intervention services due to a developmental delay or disability under the eligibility criteria of the Idaho Infant Toddler Program; (1-1-03)T

05. ~~***School District Is Enrolled As A Provider***~~ **Individualized Education Program (IEP)**. ~~*Be served by a school district or other public educational agency that is an enrolled medical assistance provider pursuant to these rules*~~ Covered by a current Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), or Services Plan (SP), developed within the previous three hundred sixty-five (365) days which indicates the need for one (1) or more medically necessary health-related services and lists all the Medicaid reimbursable services for which the school district or agency is requesting reimbursement; and ~~*(4-5-00)*~~(1-1-03)T

06. Referred By A Physician Or Other Practitioner Of The Healing Arts. ~~*Have a recommendation or referral from*~~ Recommended or referred by a physician or other practitioner of the healing arts such as a nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed and approved by the state of Idaho to

make such recommendations or referrals, for all Medicaid services for which the school district~~/other educational agency~~ or Infant Toddler Program is receiving reimbursement. ~~(3-30-01)~~(1-1-03)T

562. SERVICE-SPECIFIC ELIGIBILITY.
In addition to meeting the Medicaid eligibility requirements in Section 561 of these rules, Psychosocial Rehabilitation (PSR), Developmental Therapy, and Intensive Behavioral Intervention (IBI) have additional eligibility requirements. (1-1-03)T

01. Psychosocial Rehabilitation (PSR). To be eligible for PSR, the student must meet the PSR eligibility criteria for children in Section 450 of these rules, or the Department of Education's criteria for emotional disturbance found in the Idaho Special Education Manual available online at: http://www.sde.state.id.us/SpecialEd/manual/sped.asp. Districts are to coordinate the delivery of services if the student is receiving PSR services authorized by the Department or its designee. (1-1-03)T

02. Developmental Therapy. To be eligible for development therapy, the student must meet the criteria for development disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the Developmental Disabilities Determination Checklist available online at: http://www.sde.state.id.us/SpecialEd/medicaid. (1-1-03)T

03. Intensive Behavioral Intervention (IBI). To be eligible for IBI services the student must: (1-1-03)T

a. Meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the Developmental Disabilities Determinations Checklist; and (1-1-03)T

b. Display self-injurious, aggressive or severely maladaptive behavior evidenced by a score of minus twenty-two (-22) or below on the Scales of Independent Behavior-Revised (SIB-R), and demonstrate functional abilities that are fifty percent (50%) or less of his chronological age in at least one (1) of the following: verbal or nonverbal communication, social interaction, or leisure and play skills. (1-1-03)T

56~~2~~3. EVALUATION AND DIAGNOSTIC SERVICES.
Evaluations ~~completed shall be recommended or referred by a physician or other practitioner of the healing arts, such as a nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed and approved by the state of Idaho to make such recommendations or referrals and shall;~~ to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: ~~(4-5-00)~~(1-1-03)T

01. Recommended Or Referred By A Physician Or Other Practitioner of the Healing Arts. Be recommended or referred by a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals; (1-1-03)T

0~~1~~2. Conducted By Qualified Professionals. Be conducted by qualified professionals for the respective discipline as defined in Section 569 of these rules; ~~and~~ ~~(4-5-00)~~(1-1-03)T

0~~2~~3. Directed Toward Diagnosis. Be directed toward a diagnosis~~ and recommendations for services~~; and ~~(4-5-00)~~(1-1-03)T

0~~3~~4. Recommend Interventions. Recommend interventions to address each need. (4-5-00)

56~~3~~4. REIMBURSABLE SERVICES.
School ~~D~~districts~~/~~ and Infant Toddler ~~P~~programs may bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts~~:~~ licensed and approved by the state of Idaho to make such recommendations or referrals for the Medicaid services for which the school district or other educational agency is seeking reimbursement. ~~(4-5-00)~~(1-1-03)T

01. Annual IEP, IFSP, Or SP (Plan) Development. A physician's referral is not required to bill for

the ~~A~~annual IEP, ~~or~~ IFSP, or SP (plan) development. When the IEP team determines the student's need for health-related services, the meeting to develop the plan will be reimbursable. One (1) meeting per calendar year is reimbursable, even though the plan may be revised more frequently. School districts cannot bill separately for professionals attending the plan meeting. The plan must identify the type, frequency, duration, provider and location of each service for which it is seeking reimbursement. ~~(4-5-00)~~(1-1-03)T

02. Collateral Contact. Consultation or treatment direction about the student to a significant other in the student's life may be face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursed. ~~(7-1-99)~~(1-1-03)T

03. Developmental Therapy And Evaluation~~-And Treatment~~. ~~Assessment, treatment and instruction of the student in the acquisition of developmental milestones and activities of~~ Developmental therapy may be billed, including evaluation and instruction in daily living skills ~~that~~ the student has not gained at the normal developmental stages in his ~~or her~~ life, or is not likely to develop without training or therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability. ~~(7-1-99)~~(1-1-03)T

~~**04. Early Periodic Screening, Diagnosis, And Treatment (EPSDT) Services**. Services include age appropriate health history and health screening services. (7-1-99)~~

0~~5~~4. Medical Equipment And Supplies. ~~Includes m~~Medical equipment and supplies that are covered ~~under the Idaho~~ by Medicaid ~~program~~ must be ordered by a physician and prior authorized, based on medical necessity, in order to be billed. Authorized items must be used at school or for the Infant Toddler Program at the location where the service is provided. Equipment that is too large or unsanitary to transport from home to school may be covered if prior authorized. The equipment and supplies must be used for the student's exclusive use and transfer with the student if the student changes schools. Equipment no longer usable by the student, may be donated to the school by the student. ~~(7-1-99)~~(1-1-03)T

0~~6~~5. Nursing Services. ~~Includes s~~Skilled nursing services ~~that~~ must be provided by a licensed nurse, within the scope of his practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. ~~(7-1-99)~~(1-1-03)T

0~~7~~6. Occupational Therapy And Evaluation~~-And Treatment~~. ~~Does not include components of o~~Occupational therapy ~~that deals with~~ and evaluation services for vocational assessment, training or vocational rehabilitation are not reimbursed. ~~(7-1-99)~~(1-1-03)T

0~~8~~7. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements such as basi~~s~~c personal care and grooming; assistance with bladder or bowel requirements; assistance with eating (including feeding)~~;~~, or other tasks delegated by a ~~Registered~~ licensed professional ~~N~~nurse (RN). ~~(4-5-00)~~(1-1-03)T

0~~9~~8. Physical Therapy And Evaluation~~-And Treatment~~. ~~(7-1-99)~~(1-1-03)T

~~1~~09. Psychological Evaluation~~-And Therapy~~. ~~(7-1-99)~~(1-1-03)T

10. Psychotherapy. (1-1-03)T

11. Psychosocial Rehabilitation (PSR) And Evaluation~~-And Treatment~~. ~~Includes assistance~~ Psychosocial rehabilitation (PSR) and evaluation services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, study skills, and coping skills are reimbursed. This service is to prevent placement of the student into a more restrictive educational situation. See Section 565 of these rules for a description of individual and group PSR services. ~~(7-1-99)~~(1-1-03)T

12. Intensive Behavioral Intervention (IBI). Intensive ~~B~~behavioral ~~I~~interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which

diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. ~~*Intensive Behavioral Intervention*~~ IBI is available only to children birth through ~~*age twenty-one (21)*~~ the last day of the month of their twenty-first birthday who have self-injurious, aggressive or severely maladaptive behavior and severe deficits in the areas of verbal and nonverbal communication~~;~~, ~~*or*~~ social interaction~~;~~, or leisure and play skills. ~~*(4-5-00)*~~(1-1-03)T

a. Parent and Staff Consultation. Professionals may provide consultation to parents and to other staff who provide therapy for the child in other disciplines to assure successful integration and transition from ~~*Intensive Behavioral Intervention*~~ IBI to other therapies and environments. ~~*(5-3-03)*~~(1-1-03)T

b. Prior Authorization. ~~*Initial Intensive Behavioral Intervention services or consultation must be prior authorized by the Department. The school district/Infant Toddler Program must submit evidence of each child's eligibility for Intensive Behavioral Intervention, the Individual Education Plan listing the need for the service, the number of hours of service requested, and the measurable outcomes expected as the result of the intervention.*~~ Prior authorization for IBI services, when delivered by a school-based provider, will not be required beginning August 15, 2003. ~~*(4-5-00)*~~(1-1-03)T

~~***c.*** *Continuation of Prior Authorization. The school district/Infant Toddler Program must submit a report on the child's progress toward Intensive Behavioral Intervention outcomes to the Department every one hundred twenty (120) days and seek prior authorization for continuation or modification of services. On an annual basis, a multi-disciplinary treatment team that includes at a minimum, the parent(s), staff psychologist and staff providing services to the child, will review current evaluations and make a recommendation for continuation or modification of the intervention.*~~ ~~*(4-5-00)*~~

13. Speech/Audiological Therapy And Evaluation~~*-And Treatment*~~. ~~*(7-1-99)*~~(1-1-03)T

14. Social History And Evaluation. (7-1-99)

15. Transportation Services. School districts~~/~~ and Infant Toddler ~~*P*~~programs can receive reimbursement for mileage for transporting a student to and from home, school, or location of services when: ~~*(4-5-00)*~~(1-1-03)T

a. The student requires special transportation assistance such as a wheelchair lift, ~~*or*~~ an attendant, or both, when medically necessary for the health~~/~~ and safety of the student and ordered by a physician; ~~*and*~~ ~~*(7-1-99)*~~(1-1-03)T

b. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; ~~*and*~~ ~~*(4-5-00)*~~(1-1-03)T

c. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; ~~*and*~~ ~~*(7-1-99)*~~(1-1-03)T

d. Both the Medicaid-covered service and the need for the special transportation are included on the student's ~~*IEP or IFSP.*~~ plan; and ~~*(7-1-99)*~~(1-1-03)T

e. The mileage, as well as the services performed by the attendant, are documented. See Section 576 of these rules for documentation requirements. (1-1-03)T

16. Interpretive Services. Interpretive services ~~*are those services*~~ needed by a student who does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service~~.~~ may be billed with the following limitations: ~~*(7-1-99)*~~(1-1-03)T

a. Payment for interpretive services ~~*are*~~ is limited to the specific time that the student is receiving the health-related service~~.~~; ~~*(7-1-99)*~~(1-1-03)T

b. Both the Medicaid-covered service and the need for interpretive services ~~are~~ must be included on the student's ~~IEP or IFSP.~~ plan; and ~~(7-1-99)~~(1-1-03)T

c. Interpretive services ~~would~~ are not ~~be~~ covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. ~~(7-1-99)~~(1-1-03)T

565. PSYCHOSOCIAL REHABILITATION (PSR) SERVICES DESCRIPTION.
Psychosocial rehabilitation (PSR) services are to prevent the placement of a student in a more restrictive educational situation. The two (2) types of PSR are individual and group services. (1-1-03)T

01. Individual PSR. Individual PSR includes one (1) or more of the following services: (1-1-03)T

a. Assistance in gaining and utilizing skills necessary to undertake school, employment, or independence. This includes helping the student learn personal hygiene and grooming, selecting and acquiring appropriate clothing, time management, and other skills related to the student's psychosocial circumstances; (1-1-03)T

b. Ongoing on-site assessment, evaluation, and feedback sessions, including one hundred twenty (120) day reviews, to identify symptoms or behaviors and to develop interventions with the student and employer or teacher. The progress report may be used to satisfy this requirement; (1-1-03)T

c. Individual interventions in social skill training to improve communication skills and facilitate appropriate interpersonal behavior directly related to the student's emotional disturbance; (1-1-03)T

d. Problem solving, support and supervision related to activities of daily living to assist the student to gain and utilize skills such as personal hygiene, household tasks, use of transportation, and money management; (1-1-03)T

e. Development of coping skills and symptom management to identify the symptoms of emotional disturbance that are barriers to successful community integration and crisis prevention. (1-1-03)T

02. Group PSR. Group PSR must be provided in accordance with the goals, objectives, and benchmarks specified on the plan. This is a service provided to two (2) or more students, at least one (1) of whom is a Medicaid participant. The purpose of the service is to aid students in work, school, or other activities related to their emotional disturbance in obtaining skills to live independently or in preventing movement to a more restrictive educational situation. Group PSR must include one (1) or more of the following: (1-1-03)T

a. Employment or school-related groups to focus on symptom management on the job or in school, symptom reduction, and education about appropriate job- or school-related behaviors; (1-1-03)T

b. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior; (1-1-03)T

c. Symptom management groups to identify symptoms of emotional disturbance that are barriers to successful community integration, crisis prevention, problem identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members, and other support persons; and (1-1-03)T

d. Activities of daily living groups which help students learn skills related to personal hygiene, grooming, household tasks, use of transportation, socialization and money management. (1-1-03)T

56~~4~~6. -- 567. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

569. PROVIDER STAFF QUALIFICATIONS.
Medicaid will only reimburse for services provided by qualified staff. See Section 574 of these rules for the limitations and requirements for paraprofessional service providers. The following are the minimum qualifications for professional providers of covered services: ~~(4-5-00)~~(1-1-03)T

01. ~~Annual~~ IEP, ~~Or~~ IFSP, Or SP Plan Development. ~~Must include the professionals who completed the evaluations and recommendations for IEP or IFSP services.~~ The IEP, IFSP, or SP (plan) must be developed in accordance with the Idaho Special Education Manual or the Infant Toddler Program Implementation Manual. Plan development ~~M~~may only be billed when the ~~IEP or IFSP~~ plan includes reimbursable health-related services. ~~(7-1-99)~~(1-1-03)T

02. Collateral Contact. Contact and direction must be provided by ~~a~~ the professional who provides the treatment to the student. ~~(4-5-00)~~(1-1-03)T

03. Developmental Therapy And Evaluation~~ And Treatment~~. Must be provided by or under the direction of a developmental specialist, as set forth in IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies". ~~(5-3-03)~~(1-1-03)T

~~**04. EPSDT Screens**. May be provided by a physician, physician extender (nurse practitioner, clinical nurse specialist, or physician's assistant), or EPSDT RN screener. (4-5-00)~~

0~~5~~4. Medical Equipment And Supplies. See Section 564 of these rules. ~~(4-5-00)~~(1-1-03)T

0~~6~~5. Nursing Services. Must be provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) licensed to practice in Idaho. (4-5-00)

0~~7~~6. Occupational Therapy And Evaluation~~ And Treatment~~. Must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. ~~(7-1-99)~~(1-1-03)T

0~~8~~7. Personal Care Services. Must be provided by ~~a nurses aide (CNA) certified by the State of Idaho~~ or under the direction of, a licensed professional nurse (RN) or licensed practical nurse (LPN), licensed by the State of Idaho. When services are provided by a CNA, the CNA must be supervised by an RN. Medically-oriented services having to do with the student's physical or functional requirements, such as basic personal care and grooming, assistance with bladder or bowel requirements, and assistance with eating (including feeding), must be identified on the plan of care and may be delegated to an aide in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing". ~~(4-5-00)~~(1-1-03)T

0~~9~~8. Physical Therapy And Evaluation~~ And Treatment~~. Must be provided by an individual qualified and ~~registered~~ licensed to practice in Idaho. ~~(7-1-99)~~(1-1-03)T

~~1~~09. Psychological ~~Therapy~~ Evaluation~~ And Treatment~~. Must be provided by a: ~~(7-1-99)~~(1-1-03)T

a. ~~A l~~Licensed psychiatrist; ~~(7-1-99)~~(1-1-03)T

b. Licensed physician; (7-1-99)

c. Licensed psychologist; (5-3-03)

d. Psychologist extender registered with the ~~Board~~ Bureau of Occupational Licenses; or ~~(7-1-99)~~(1-1-03)T

~~**e.** Certified psychiatric nurse; (7-1-99)~~

~~f~~e. Certified school psychologist~~;~~. (7-1-99)

~~***g.*** *Licensed clinical professional counselor; or*~~ ~~*(5-3-03)*~~

~~***h.*** *Licensed masters social worker or licensed clinical social worker.*~~ ~~*(5-3-03)*~~

10. **Psychotherapy**. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (11-1-03)T

a. Psychiatrist, M.D.; (11-1-03)T

b. Physician, M.D.; (11-1-03)T

c. Licensed psychologist; (11-1-03)T

d. Licensed clinical social worker; (11-1-03)T

e. Licensed clinical professional counselor; (11-1-03)T

f. Licensed marriage and family therapist; (11-1-03)T

g. Certified psychiatric nurse (R.N.), as described in Section 456 of this chapter of rules; (11-1-03)T

h. Licensed professional counselor whose provision of psychotherapy is supervised by persons qualified under Subsections 569.10.a. through 569.10.g. of this rule; (11-1-03)T

i. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or (11-1-03)T

j. Psychologist extender registered with the Bureau of Occupational Licenses. (11-1-03)T

11. **Psychosocial Rehabilitation**. Must be provided by a: ~~*(7-1-99)*~~(11-1-03)T

a. ~~*A l*~~Licensed physician or psychiatrist; ~~*(7-1-99)*~~(11-1-03)T

b. Licensed ~~*physician*~~ master's level psychiatric nurse; ~~*(7-1-99)*~~(11-1-03)T

c. Licensed psychologist; (7-1-99)

d. ~~*Psychologist extender registered with the Board of Occupational Licenses*~~ Licensed clinical professional counselor or professional counselor; ~~*(7-1-99)*~~(11-1-03)T

e. ~~*Certified psychiatric nurse*~~ Licensed marriage and family therapist; ~~*(7-1-99)*~~(11-1-03)T

f. ~~*Certified school psychologist*~~ Licensed masters social worker, clinical social worker, or social worker; ~~*(7-1-99)*~~(11-1-03)T

g. ~~*Licensed clinical professional counselor*~~ Psychologist extender registered with the Bureau of Occupational Licenses; ~~*(5-3-03)*~~(11-1-03)T

h. ~~*Licensed social worker, licensed masters social worker or licensed clinical social worker*~~ Clinician; ~~*or*~~ ~~*(5-3-03)*~~(11-1-03)T

i. ~~*Psychosocial rehabilitation specialist as defined in Section 455 of these rules.*~~ Licensed pastoral counselor; ~~*(5-3-03)*~~(11-1-03)T

j. Licensed professional nurse (RN); (11-1-03)T

k. Psychosocial rehabilitation specialist as defined in Section 456 of this chapter of rules; (11-1-03)T

l. Licensed occupational therapist; (11-1-03)T

m. Certified school psychologist; or (11-1-03)T

n. Certified school social worker. (11-1-03)T

12. Intensive Behavioral Intervention. Must be provided by or under the direction of a qualified professional who meets the requirements set forth in IDAPA 16.04.11 "Rules Governing Developmental Disabilities Agencies," Section 809, "Qualifications to Provide Intensive Behavioral Intervention". (5-3-03)

13. Speech/Audiological Therapy And Evaluation~~ *And Treatment*~~. Must be provided by or under the direction of a speech pathologist or audiologist who possesses a certificate of clinical competence from the American Speech, Language and Hearing Association (ASHA); or who will be eligible for certification within one (1) year of employment. Personnel records must reflect the expected date of certification. ~~*(4-5-00)*~~(1-1-03)T

14. Social History And Evaluation. Must be provided by a ~~*registered*~~ licensed professional nurse~~;~~ (RN), psychologist~~;~~, M.D~~;~~, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. ~~*(4-5-00)*~~(1-1-03)T

15. Transportation. Must be provided by an individual who has a current Idaho driver's license and ~~*be*~~ is covered under vehicle liability insurance that covers passengers for business use. ~~*(4-5-00)*~~(1-1-03)T

(BREAK IN CONTINUITY OF SECTIONS)

575. PAYMENT FOR SERVICES.
Payment for health-related services provided by school districts~~/~~ and Infant Toddler programs must be in accordance with rates established by the Department. ~~*(4-5-00)*~~(1-1-03)T

01. Matching Funds. School districts and ~~*the*~~ Infant Toddler ~~*P*~~programs are responsible for certification of the state portion of the Medicaid payment and ~~*shall*~~ must document, as part of their fiscal records, the non-federal funds that have been designated as their certified match. ~~*(4-5-00)*~~(1-1-03)T

02. Payment In Full. Providers of services must accept as payment in full the Department's payment for such services and must not bill Medicaid ~~*recipients*~~ participants for any portion of any charges. ~~*(4-5-00)*~~(1-1-03)T

03. Third Party. ~~*Third party payment resources, not to include other school or agency resources, such as private insurance, must be exhausted before the Department is billed for services. Proof of billing other third party payers is required.*~~ For requirements regarding third party billing, see Section 030 of this chapter of rules. ~~*(4-5-00)*~~(1-1-03)T

04. Contracted Providers. A contracted provider of the school program may not submit a separate claim to Medicaid as the performing provider for services provided under the school-based program and codes. A contracted provider of a school program must accept the payment from Medicaid as payment in full and must not bill a participant for any portion of any charges. ~~*(4-5-00)*~~(1-1-03)T

05. Inpatients In Hospitals Or Nursing Homes. Payment for school~~/~~-related or Infant Toddler-based ~~*related*~~ services will not be provided to students who are inpatients in nursing homes or hospitals. Health-related services for students residing in an ICF/MR are eligible for reimbursement. ~~*(4-5-00)*~~(1-1-03)T

06. Recoupment Of Federal Share. Failure to provide services for which reimbursement has been received or to comply with these rules ~~*and procedural guidelines established by the Department,*~~ will be cause for

recoupment of the Federal share of payments for services, sanctions, or both. ~~(4-5-00)~~(1-1-03)T

07. Access To Information. The provider will grant the Department immediate access to all information required to review compliance with these rules. (4-5-00)

576. RECORD REQUIREMENTS.
In addition to the evaluations and maintenance of the ~~*Individualized Education Program (IEP) plan or Individualized Family Service Plan (IFSP)*~~ plans, the following documentation must be maintained by the provider and retained for a period of six (6) years: ~~(5-3-03)~~(1-1-03)T

01. Service Detail Reports. A service detail report which includes: (4-5-00)

a. Name of student; (7-1-99)

b. Name and title of the person providing the service; (7-1-99)

c. Date, time, and duration of service; ~~*and*~~ ~~(7-1-99)~~(1-1-03)T

d. Place of service~~.~~, if provided in a location other than school; and ~~(7-1-99)~~(1-1-03)T

e. Student's response to the service. (1-1-03)T

~~***02. Activity Record**. An activity record completed at the time the service was provided which describes the service provided and the student's response to the service.*~~ ~~(4-5-00)~~

0~~3~~2. One Hundred ~~*And*~~ Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual ~~*IEP/IFSP*~~ plan. ~~(4-5-00)~~(1-1-03)T

0~~4~~3. Documentation Of Qualifications Of Providers. (4-5-00)

0~~5~~4. Copies Of Required Referrals And Recommendations. Copies of required referrals and recommendations. (4-5-00)

0~~6~~5. Parental Notification. ~~*Documentation that the*~~ School ~~*D*~~districts and Infant~~/~~ Toddler ~~*P*~~programs must document that parents were notified ~~*the student's parents*~~ of the health-related services ~~*that*~~ and equipment for which they ~~*intended to*~~ will bill ~~*to*~~ Medicaid. Notification must ~~*describe the service and state the type, amount, and frequency of the service*~~ comply with the requirements in Section 577 of these rules. ~~(4-5-00)~~(1-1-03)T

577. REQUIREMENTS FOR COOPERATION ~~*OF SERVICES*~~ WITH AND NOTIFICATION OF PARENTS AND AGENCIES.
Each school district or ~~*public educational agency*~~ Infant Toddler Program billing for Medicaid services ~~*shall*~~ must act in cooperation with students' parents and with community and~~/or~~ state agencies and professionals who provide like Medicaid services to the student. ~~(4-5-00)~~(1-1-03)T

01. Notification Of Parents. For all students who are receiving Medicaid reimbursed services, ~~*the S*~~school ~~*D*~~districts~~/~~ and Infant Toddler ~~*P*~~programs ~~*shall*~~ must ensure that parents are notified of the Medicaid services ~~*that the school/agency will be submitting for reimbursement in relationship to their child*~~ and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration or the service(s). The school district ~~*shall*~~ must provide the student's parent~~/~~ or guardian with a current copy of the child's ~~*IEP or IFSP*~~ plan and any pertinent ~~*addendums.*~~ addenda; and ~~*The IEP/IFSP or addendum shall describe the Medicaid reimbursable service and list the type, amount and frequency of that service.*~~ ~~(4-5-00)~~(1-1-03)T

02. ~~*Healthy Connection Program*~~. ~~*Students in the Healthy Connection Program. School Districts/ Infant Toddler Program shall also provide to the Healthy Connection physician or practitioner of the healing arts a copy of the results of the evaluations that the physician/practitioner ordered, recommended or referred. A copy of the*~~

~~*current IEP or IFSP which lists the therapies/services that resulted from the ordered evaluations, and quarterly progress notes for those therapies/services. Evaluations, IEPs or IFSPs, and progress notes shall be provided to the physician within sixty (60) days of completion.*~~ **Notification To Primary Care Physician**. School districts and Infant Toddler programs must request the name of the student's primary care physician from the parent or guardian so the school program can share health-related information with the physician. The following information must be sent to the student's primary care physician: ~~*(4-5-00)*~~(1-1-03)T

a. Results of evaluations within sixty (60) days of completion; (1-1-03)T

b. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and (1-1-03)T

c. A copy of progress notes, if requested by the physician, within sixty (60) days of completion. (1-1-03)T

03. Other Community~~/~~ And State Agencies. ~~*Students who receive like Medicaid services through other community and/or state agencies and professionals.*~~ Upon receiving a request for a copy of the evaluations or the current ~~*IEP or IFSP*~~ plan, the school district~~/ *public educational agency will*~~ or Infant Toddler Program must furnish the requesting agency or professional with a copy of the ~~*IEP or IFSP*~~ plan or appropriate evaluation after obtaining consent for release of information from the student's parent~~/~~ or guardian. ~~*(4-5-00)*~~(1-1-03)T

04. Parental Consent To Release Information. School districts and Infant Toddler programs: (1-1-03)T

a. Must obtain consent from the parent to release information regarding education-related services, in accordance with Federal Education Rights and Privacy Act (FERPA) regulations; (1-1-03)T

b. Must document the parent's denial of consent if the parent refuses to consent to the release of information regarding education-related services; and (1-1-03)T

Subject Index

A

AAA Assessments Of Providers 13
AAA Budget Forms & Revisions 10
AAA Designation 9
AAA Provider Appeals 11
AAA Provider Subcontracts 10
AABD Criteria 100
AABD Resource Limit 100
Abbreviations, IDAPA 16.03.01, Rules Governing Eligibility For Medicaid For Families And Children 41
Able Bodied Adults Without Dependents (ABAWD) Work Requirement 89
Abortion 180
Abortion Procedures 145
Abuse Or Abusive 192, 266
Access To Documentation & Records 266
Access Unit (ACCESS) 180
Activities Of Daily Living (ADL) 180
Actual & Anticipated Income 60
Additional Covered Drug Products 149, 154
Adjunctive General Services 222
Administrative Review For Enforcement Of Medical Support, Child Support 64
Admission To A Nursing Facility 140
Adulterated Or Misbranded Food 33
Advances On Wages 72
Advising Consumers Of Health Risk Of Raw Or Undercooked Foods 33
AFDC 41
AG 41
Age, Home And Community Based Services 100
Aged & Disabled (A&D) Waiver 111, 117
Aggravating Factors, Mandatory Exclusions, Medical Assistance 270
Agricultural Market 28
AIM 41
Allowable Costs, AAA Operations 14
Amalgams & Resin Restoration, Dental Restorative Procedures 213
Ambulatory Surgical Center (ASC) 180
Ambulatory Surgical Center, Eligible Recipients 275
American Indian Born In Canada 52, 56, 87, 104, 109
American Indian Born Outside The U.S. 52, 56, 88, 104, 109
Amphetamines And Related Products 153
Annual Eligibility Redetermination 287
Annual IEP, IFSP, Or SP (Plan) Development 296
Annual Limit, HCBS-NF Or HCBS-DD 100, 117
Anterior Proximal Restoration, Dental Restorative Procedures 213
Appeal Process 38
Appeals, Medical Assistance 271
Application For A License 34
Application For SSN 59, 114
Application For SSN, Food Stamps 83
Approval of Process Methods 32
Area Advisory Councils On Aging, AAA Operations 12
Area Agency On Aging (AAA) 8
Area Plan 8
Area Plans, AAA Operations 13
Assessment Process Approved By The Department 136
Assets Returned, Asset Transfers 118
Assignment Of Person In Charge 24
ASVI 41
Asylees, Citizenship/Legal Non-Citizen Requirement 99
Asylees, Eligibility For Medicaid For Families/Children 43
Asylees, Food Stamp Program 69
Attendant Care 180
Audits 14
Authorization Of Services 137
Authorization Of Services On A Written Plan, Developmentally Disabled Recipients 256
Authorization Of Services, Medical Assistance 257
Authorized Provider 180

B

Basic Allowance For Housing (BAH) 90
Basis For Suspension Of Payments 269
Battered Non-Citizen Admitted Before August 22, 1996 98
Battered Non-Citizen Admitted Before August 22, 1996, Eligibility For Medicaid For Families, Children 55
Battered Non-Citizen Admitted Before August 22, 1996, Eligibility For Medicaid For Families/Children 43
Battered Non-Citizen Admitted On Or After August 22, 1996 99
Battered Non-Citizen Admitted On Or After August 22, 1996, Eligibility For Medicaid For Families, Children 55
Battered Non-Citizen Admitted On Or After August 22, 1996, Eligibility For Medicaid For Families/Children 44
Battered Non-Citizen, Food Stamp Program 69
BCSS 41
Behavior Consultation/Crisis Management 136
Behavior Consultation/Crisis Management Service Providers 139
Behavior Shaping And Management 133
Benefit Of Spouse, Assets 118
Bill 180
Billed Services Not Provided Or Not Medically Necessary, Denial Of Payment, Medical Assistance 268
Blind Review 8
Bottled Water Processing 32
Brand Name Drugs, Limitations On Payment by Department 147, 152
Budget Revisions, AAA Operations 10
Buy-In Coverage 180

C

Calculation Of Fees, Provider Reimbursement 141
Care By Household Member 92
Care Requirement, HCBS-NF Or HCBS-DD 100
Carl D. Perkins Vocational And Applied Technology Education Act 46
Case Management In A Facility, Medicaid Reimbursement 160, 172, 239
Case Management Services, CM Services 157, 168
Case Redetermination, Adult Developmentally Disabled Recipients 261
Cash Donations, Excluded Income 90
Category I Sanctions 180
Category II Sanctions 180
Central Office 181
Certain Hmong & Highland

Laotians 88
Certain Hmong And Highland Laotians, Food Stamp Program 69
Certified Registered Nurse Anesthetist (CRNA) 181
Change In Resource Limit 71
Child Support Deduction, Income 73
Child Support Income Disregard, TAFI 48
Child Support Payments 90
CHIP 41
Choice Of Providers 200
Chore Service Providers 138
Chore Services 133
Citizenship & Legal Non-Citizen Criteria, TAFI Eligibility 122, 124, 125
Citizenship & Legal Non-Citizen Requirement 96, 104, 108
Citizenship & Legal Non-Citizen Requirement, AABD 107
Citizenship & Legal Non-Citizen Requirement, Eligibility For Medicaid For Families, Children 54
Citizenship & Qualified Non-Citizen Requirements 79, 86
Citizenship & Qualified Non-Citizen Requirements, Eligibility For Medicaid For Families, Children 52, 55
Citizenship And Legal Non-Citizen Requirement 98
Citizenship And Legal Non-Citizen Requirement, Eligibility For Medicaid For Families/Children 42
Citizenship Or Satisfactory Immigration Status, Food Stamp Program 68
Civil Monetary Penalties, Medical Assistance 269
Civil Proceedings 39
Civil Rights, AAA Operations 14
Claim, Itemized Bill for Services 181
Claim, Request Or Demand For Payment 192, 266
Client Eligibility, Denturist Policy Guidelines 226
Clients Eligible For Other Programs 231
Clinical Licensed Professional Counselor 158
CM Provider Agency Qualifications 158, 170
Collateral Contacts 181
Collecting Claims Against Sponsored Legal Noncitizens 94
Collecting Claims Against Sponsors Who Signed An I-864 Affidavit Of Support On Or After December 19, 1997 94
Combination Of Work & Work Programs, ABAWD Work Requirement 89
Committed An Offense Or Act Not In Best Interest Of Medicaid Recipients 271
Community Living Home 181
Competitive Bids, AAA Operations 10
Complaints Against AAA Employees 14
Compliance & Enforcement 33
Compliance Conference 38
Comprehensive Orthodontic Treatment 221
Conditional Entrants 99
Conditional Entrants, Eligibility For Medicaid For Families, Children 54
Conditional Entrants, Eligibility For Medicaid For Families/Children 43
Conditional Entrants, Food Stamp Program 69
Confidentiality, Written Informed Consent For Release 177
Consent Order 29
Consumption Of Animal Foods That Are Raw, Undercooked, Or Not Otherwise Processed To Eliminate Pathogens 33
Continued Services, HCBS 100
Contraception 181
Contract Management Requirements, AAA Operations 10
Contracts Term 10
Contrary To Rules Or Provider Agreement 268
Converting Income To An Annual Amount 60
Convicted Of A Felony 271
Conviction Of A Criminal Offense Related To Patient Neglect Or Abuse, Mandatory Exclusions 270
Conviction Of A Criminal Offense, Mandatory Exclusion 270
Conviction, Criminal Offense 192, 266
Cooling Cooked Potentially Hazardous Food 31
Cooling Costs, Standard Utility Allowance (SUA) 74
Copies Of Required Referrals & Recommendations 303
Copying Records 267
Cost Of Care, HCBS-NF 100, 116
Counting Out-Of-State Temporary Assistance To Needy Families (TANF) Benefits 48
Counting Temporary Assistance To Families In Idaho (TAFI) Income 48
Coverage Limits, Specified Low Income Medicare Beneficiary 102
Covered Surgical Procedures, Medical Assistance 275
Criminal & Civil Proceedings 39
Criminal History Check 287
Criminal Proceedings 39
Crisis Case Management 159, 238
Crisis Case Management, CM Services 157
Criteria For Determining Need For NF Care, Medical Assistance 234
Critical Indicator, Criteria For Determining Need For NF Care 234
Crowns, Dental Restorative Procedures 213
Custom Meat 30
Customary Fees, Dental Services 210

D

Daily Living Skills, Habilitation Services 133
Day Rehabilitation Providers 140
Day Rehabilitation, Four Hours Or More A Day On A Regularly Scheduled Basis 136
Day's Supply, Limitations On Payment by Department 147, 152
Decreases Or Closure Of Food Stamps 81, 92
Definitions, IDAPA 15.01.20, Rules Governing Area Agency On Aging (AAA) Operations 8
Definitions, IDAPA 16.02.19, Food Safety & Sanitation Standards For Food Establishments 28
Definitions, IDAPA 16.03.09 180
Definitions, Medical Assistance, Fraud, Abuse & Misconduct 266
Definitions, Sections 200 Through 233 192

Demonstration Of Knowledge 30
Denial Of AAA Designation 9
Denial Of Payment, Medical Assistance 268
Denial Or Termination Of Service 13
Dental Covered Benefits & Limitations, Dental Services 210
Dental Diagnostic Procedures 210
Dental Preventive Procedures 211
Dental Prior Authorization 231
Dental Restorative Procedures 212
Dental Services 210
Denturist Policy Guidelines 207, 225
Denturist Procedure Codes 208, 226
Department 181
Department Actions, Medical Assistance, Fraud, Abuse, Misconduct 268
Dependent Care Deduction, Income 73
Dependent Care Disregard, Eligibility For Medicaid For Families/ Children 45
Dependent Care Restrictions 92
Dependent Child, Medicaid Coverage/ AFDC Standards 48
Dependent Income 101
Deportation Withheld 99
Deportation Withheld, Eligibility For Medicaid For Families, Children 54
Deportation Withheld, Eligibility For Medicaid For Families/Children 43
Deportation Withheld, Food Stamp Program 69
Development Of The Plan Of Care 136
Developmental Therapy 291, 296
Developmental Therapy & Evaluation 291, 300
Developmentally Disabled (DD) Waiver 117
DHW 41
Diagnostic Criteria 132
Diet Supplements 153
Director 181
Disqualified Parents, Must Be Included/ AFDC-Related Medicaid Budget Unit 44
Disregard Expired, TM 49
Documentation Of Services & Access To Records, Medical Assistance 267
DOE 41
Doses Of Medication 155
Drug Convicted Felon, Food Stamps/ Disqualified Household Members 89
Durable Medical Equipment (DME) 181
Duration Of Suspension Of Payments 269
Duties Of The Designated PRO, In-Patient Hospital Services 190
DVR 41

E

Early And Periodic Screening, Diagnosis, And Treatment (EPSDT) Service Coordination 173
Earned Income 89
Earned Income Deduction 73
Earnings Of Child Under Age Eighteen Attending School 90
Education Exclusion 92
Educational Disability 290, 295
Educational Income, Eligibility For Medicaid For Families/Children 46
Educational Services 181
EE 41
Effective Date of Revocation 38
Effective Date, Medicaid 100, 117
Effective Dates, Qualified Medicare Beneficiary 101
Effective Dates, Specified Low Income Medicare Beneficiary 102
EITC 41
Eligibility Manuals 181
Eligibility, AAA Operations 13
Eligibility, Business Enterprise Program, Blind & Visually Impaired 17
Eligible For Long Term Care, HCBS-NF 100
Eligible Target Group, Developmental Disabilities Service Coordination 162
Eligible Target Group, Developmental Disabilities, Medical Assistance 245
Eligible Target Group, Mentally Ill 167
Embargo 29
Embargo Order Is Effective When Served 37
Embargo Release 37
Emergency 182
Emergency Situation, Prior Authorization, Pharmaceutical 149
Employee Health 30
Employment Income Increased, TM 49
Employment Or School 70
Employment Or School In Another Area 70
Endangerment Of Health Or Safety Of A Patient 193
Endangerment Of Health Or Safety Of A Patient, Medical Assistance 270
Endangerment Of Life 182
Endodontics 215
Energy Assistance Excluded From Income, Standard Utility Allowance (SUA) 74
Energy Assistance Not Excluded From Income, Standard Utility Allowance (SUA) 74
Enforcement Inspection 29
Enforcement Inspections 36
Enforcement Inspections On Consent Order 36
Enforcement Procedures For Adulterated Or Misbranded Food 36
Environmental Accessibility Adaptations 134
Environmental Barriers 70
Environmental Modifications Service Providers 139
EPICS 41
EPSDT 41
Evaluation & Diagnostic Services, Developmental Disabilities Centers 250
Evaluation & Diagnostic Services, School Based Programs 291, 296
Evaluation/Service Plan Development 172
Evaluation/Service Plan Development, Payment Of Services, Medical Assistance 238
Exception For Religious Objection 84
Exception To Fair Market Value 119
Exceptions To Sponsor Deeming 92
Excess Medical Deduction 73
Excluded As A Personal Residence 136
Excluded Drug Products 153
Excluded Income 90
Excluded Real Estate Contract, AABD 111, 114
Exclusion 193, 266
Exclusions From Supported

Employment 134
Exempt Trusts 119
Extended State Plan Service Providers 139
Extended State Plan Services 135

F

Facility Approval, ASC 275
Failed To Repay 271
Failure To Apply For SSN 59, 114
Failure To Comply With A Requirement Of Another Means-Tested Program 71
Failure To Cooperate In Paternity Establishment Or Obtaining Support, Food Stamp/Disqualified Household Members 89
Failure To Disclose Or Make Available Records 194
Failure To Disclose Or Make Available Records, Medical Assistance 270
Failure To Provide Immediate Access To Records 268
Family Emergencies 70
Federal Earned Income Tax Credit (EITC) 91
Federal Financial Participation (FFP) 134
Fee For Services, Based On Type Of Service 141
Field Dressed Game Animals 31
Financial Deprivation, Medicaid Coverage/AFDC Standards 49
Financial Eligibility, Eligibility For Medicaid For Families/Children 44
Financial Management, AAA Operations 14
Financial Responsibility, Eligibility For Medicaid For Families/Children 44
FMHA 42
Follow-Up Inspection 36
Food Establishment 29
Food License Expiration 34
Food Processing Plant 29
Food Processing Plants 32
FPG 42
Fraud Or Fraudulent 193, 266
Fraud Victim 119
Fugitive Felon, Food Stamp/ Disqualified Household Members 88
Full Time Job Does Not Develop 70
Full-Time Active Duty U.S. Armed Forces Member 55, 87, 108, 125
Functional Level, Adults, Determining Need For NF Care 234

G

Game Animals 31
Garnishments Held By Employer 72
Good Cause For Not Applying For SSN, Food Stamps 84, 129
Good Cause For Voluntarily Quitting A Job Or Reducing Work Hours 70
Gross Income Limit 72
Group PSR 299

H

Habilitation Services 133
HCBS Income Limit 100
Health Authority 182
Heating Costs, Standard Utility Allowance (SUA) 74
High Indicator, Criteria For Determining Need For NF Care 234
High-Risk Food Establishment 29, 35, 36
Home & Community Based Services (HCBS) 116
Home & Community-Based Waiver Participant Limitations, Adult Developmentally Disabled Recipients 263
Home And Community-Based Waiver Recipient Limitations 142
Home Delivered Meal Services 139
Home Delivered Meals 135
Home Health Services 182
Home To Adult Child, Assets 118
Home To Brother Or Sister, Assets 118
Home To Minor Child Or Disabled Adult Child, Assets 118
Home To Spouse, Assets 117
Hospital Penalty Chart 191
How To Inform Consumers Of Health Risk 33
HUD 42

I

ICF/MR 42
ICSES 42
Idaho Commission On Aging (ICOA) 8
Idaho State School & Hospital (ISSH) Waiver 117
Idaho TAFI Income And Income From Employment, TM 49
IEP, IFSP, Or SP Plan Development 300
IEVS 42
Immediate Access To Records 267
Impotency Aids 153
INA 42
Included In The Plan Of Care 137
Income Deductions 66, 73
Income Eligibility 59
Income Excluded By Federal Law, Eligibility For Medicaid For Families/Children 46
Income In Kind 90
Income Limit 116
Income Not Counted 115
Income Trust 120
Income, QMB 101
Income, SSI Cost Of Living Increase 101
Individual PSR 299
Individual Support Plan, Provider Records 142
Individualized Education Program (IEP) 290, 295
Individuals Not Meeting The Citizenship Or Qualified Non-Citizen Requirements 56, 105, 109
Ineligible Aliens, Food Stamp/ Disqualified Household Members 88
Informed Consent, EPSDT 177
Infrequent Or Irregular Income 90
Injunctive Relief 39
In-Kind Payment, Dependent Care 92
In-Patient Hospital Services 189
In-Patient Hospital Services, Ordinarily Furnished In A Hospital 182
Inpatients In Hospitals Or Nursing Homes, Infant Toddler Program Payment 302
Inspection Of Care Team (IOCT) 182
Inspection Scores 35
Inspections & Correction Of Violations 35
In-State Care 182
Instrumental Activities Of Daily Living (IADL) 182
Intake/Pre-Screening, CM Provider Agency 170
Intensive Behavioral Intervention (IBI) 296

Intensive Behavioral Intervention, Reimbursable Services 297
Intent To Get Fair Market Value 118
Interceptive Orthodontics 221
Interested Physician 182
Intermediate Care Facility Services 182
Investigation & Audits, Potential Instances Of Fraud, Abuse, Misconduct, Medical Assistance 267
Investigation Methods, Potential Instances Of Fraud, Abuse, Misconduct 267
Investigation Pending 271
IRS 42
Items Requiring Prior Authorization, Pharmaceutical 148

J

JSAP Or Work Registration Noncompliance, Food Stamp/ Disqualified Household Members 88

K

Knowingly, Known, Or With Knowledge 193, 266

L

Labeling Of Medicines 33
Law Enforcement Authority 182
Lawful Non-Citizen, Permanent Residents Residing In The U.S. On August 22, 1996, Food Stamp Program 68
Lawful Non-Citizen, Permanent Residents Who Are Blind Or Disabled, Food Stamp Program 68
Legal Permanent Resident (LPR) Entering On Or After August 22, 1996 56, 109, 126
Legal Representative 183
Legend Drug 183
Legend Drugs, Excluded Drug Product 153
License Holder 29
License Is Non-Transferable 34
Licensed Marriage & Family Therapist 159
Licensed Psychologist 183
Licensed, Qualified Professionals 183
Limit On The Number Of Area Agencies & PSA's 9
Limitation Of Quantities, Required Medication 155
Limitations On Payment 147, 152
Limitations To Discourage Waste, Financial Obligations Of Recipients 148, 152
Limited Orthodontics 221
Linking/Coordination Of Services 158, 170
Living With A Relative, Medicaid Coverage/AFDC Standards 48
Loans, Excluded As Income 91
Lock-In Option, Choice Of Providers 200
Lock-In Program 183
Locum Tenens/Reciprocal Billing 183
Long-Term Care Resident & Medicaid 115
Low Income Families With Children, Medicaid Coverage/AFDC Standards 48
Low-Risk Food Establishment 29

M

MA 42
Maintained In The Community, HCBS 100, 116
Management & Personnel 30
Managing Employee 193, 266
Mandatory Exclusions From The Medicaid Program, Medical Assistance 269
Maximum Food Stamps By Household Size 77
Meat & Poultry 30
Medicaid Eligibility, School Based Program 295
Medicaid Income Limit Of Long-Term Care Resident Less Than Thirty Days 115
Medicaid Income Limit Of Long-Term Care Resident Thirty Days Or More 115
Medical Assistance 193, 266
Medical Care & Services Provided 284
Medical Care Provided Outside The State Of Idaho, Choice Of Providers 200
Medical Care Treatment Plan 183
Medical Insurance, Business Enterprise Program, Blind & Visually Impaired 17
Medical Necessity 183
Medical Necessity Criteria, EPSDT 173
Medical Supplies 183
Medicare Part A, QMB 101
Medicare Part A, SLMB 101
Medication For Multiple Persons, Financial Obligation Of Recipient 147, 152
Medications Utilized For Cosmetic Purposes 154
Medicines Allowed In A Food Establishment 33
Medicines Stored Are Not Accessible 33
Medicines Stored In A Leak Proof Container 33
Medium Indicator, Criteria For Determining Need For NF Care 234
Medium-Risk Food Establishment 29, 35, 36
Minor Treatment To Control Harmful Habits, Orthodontics 222
Misrepresentation Of Services 188
Mobility, Enhancing Movement In Home And Community 133
Money For Third Party Care 91
Money Management, Habilitation Services 133
Money Withheld, Excluded Income 90
Morbid Obesity 183

N

Native Americans, Food Stamp Program 69
Net Income Limit Test 74
NF Level of Care, Adults, Determining Need For NF Care 235
NF Level Of Care, Children 235
Nicotine Products 153
No Benefit To Participant, Asset Transfer 119
No Prior Authorization, Financial Obligations Of Recipients 147, 152
Non-Citizen Entering On Or After August 22, 1996 55, 108, 125
Non-Citizen Entering The U.S. Before August 22, 1996 55, 108, 125
Nonfinancial Requirements, QMB 101
Nonfinancial Requirements, SLMB 101
Non-Legend Drug 183
Non-Legend Medications 153

Non-Medical Care & Services Provided 285
Non-Profit Agency Contractors 10
Nonrecurring Lump Sum Payments And Capital Gains 72
Notice Of Suspension Of Payments 269
Notice To Revoke A License 37
Notification Of Parents 303
Notification To Primary Care Physician 292, 304
Nurse Midwife 183
Nurse Practitioner 184
Nursing Facility (NF) 184
Nursing Service Providers 139

O

Occupied And Unoccupied Home, Standard Utility Allowance (SUA) 74
One Hundred & Twenty Day Review, IEP 303
One Hundred Eighty-Five Percent Test, Medicaid Coverage/AFDC Standards 49
On-Going Case Management, Medicaid Reimbursement 173
On-Going Non-Crisis Case Management, Medicaid Reimbursement 160, 239
On-The-Job Training Programs 90
Operator Benefits, Business Enterprise Program, Blind & Visually Impaired 17
Oral Contraceptive Products 155
Oral Surgery 219
Orthodontics 220
Orthotic 184
Orthotic And Prosthetic Professional 184
Other Community & State Agencies 304
Other Exclusions, Secretary Of Health And Human Services 194
Other Medicaid, SLMB I 101
Other Public Education Agency 184
Otologist 184
Out-Of-State Care 185
Out-Patient Hospital Services 184
Out-Patient Hospital Services, On Site Services Eligible For Payment 191
Overissuance Due To Incorrect Sponsor Data 94
Overview, Denturist Policy Guidelines 225
Ovulation/Fertility Drugs 153
Ownership Or Control Interest 193, 267
Oxygen-Related Equipment 185

P

PA Entitlement, Idaho Food Stamps 72
Paid Or Reimbursed Dependent Care 92
Parental Consent To Release Information 292, 304
Parental Notification 303
Parents, Must Be Included/AFDC-Related Medicaid Budget Unit 44
Parolees 99
Parolees, Eligibility For Medicaid For Families, Children 54
Parolees, Eligibility For Medicaid For Families/Children 43
Parolees, Food Stamp Program 69
Participant 185
Participant Eligibility Determination 283
Participant Eligibility Determination, Waiver Eligibility 140
Participant In A Certified Family Home 288
Participant In A Residential Or Assisted Living Facility 288
Participant With Spouse, HCBS 100
Participant's Choice, TSC, Medical Assistance 248
Participate In JSAP Or Another Work Program 89
Participate In Work Opportunities, Must Comply With ABAWD Work Requirements 89
Patient 185
Payment For Services 159, 171, 176
Payment For Services, Infant Toddler Program 292, 302
Payment For Services, Medical Assistance 238
Payment For Services, TSC 166
Payment Methodology, Surgical Procedures, Medical Assistance 275
Payment Procedures, In-Patient Hospitals 190
Payment, Denturist Policy Guidelines 226
Payments Under Title I 90
PCS Record Requirement - Participant In His Own Home 273, 288
Penalty Exceptions For Asset Transfers 112, 117
Penalty For Failure To Comply With A Requirement Of Another Means-Tested Program 71
Performance Standards For A Primary Location 20
Periodontics 216
Permanent Resident Receiving AABD Cash On August 22, 1996 105, 109
Permanent Residents Admitted Before August 22, 1996 98
Permanent Residents Admitted Before August 22, 1996, Eligibility For Medicaid For Families, Children 54
Permanent Residents Admitted Before August 22, 1996, Eligibility For Medicaid For Families/Children 43
Permanent Residents Admitted On Or After August 22, 1996 96, 98
Permanent Residents Admitted On Or After August 22, 1996, Eligibility For Medicaid For Families, Children 54
Permanent Residents Admitted On Or After August 22, 1996, Eligibility For Medicaid For Families/Children 43
Permanent Residents, Food Stamp Program 68
Permissive Exclusions From The Medicaid Program, Persons Or Entities, Medical Assistance 270
Permissive Exclusions, Persons Or Entities 193
Person 193, 267
Person Entitled To Home And Community Based Services (HCBS) 100
Person Refusing To Provide SSN, Food Stamp/Disqualified Household Members 88
Personal Assistance Agency 185
Personal Assistance Agency (PAA) 283
Personal Assistance Services 133
Personal Assistance Services (PAS) 185
Personal Assistance Services Skills Training 133
Personal Care Service Providers 140
Personal Care Services (PCS) 273, 282

Personal Care Services, Assistance Due To A Medical Condition Which Impairs Physical Or Mental Function 135
Personal Difficulties 70
Personal Emergency Response Systems 139
Personal Emergency Response Systems (PERS) 135
Personal Interview, AABD 98
Persons Disqualified As Food Stamp Household Members 88
Persons Who Must Be Included In An AFDC-Related Medicaid Budget Unit 44
Persons With Citizenship Questionable, Food Stamp/Disqualified Household Members 88
Persons With IPV, Food Stamp/ Disqualified Household Members 88
Physician 185
Physician Excluded From The Penalty 188
Physician Penalties For Late PRO Review 188
Physician Penalty Chart 188
Physician Services 187
Physician's Assistant 185
Place Of Service Delivery 285
Place Of Service Delivery, Developmentally Disabled Recipients 256
Place Of Service Delivery, Traumatic Brain Injury 136
Plan Of Care 185
Plan Of Care, Provider Records 142
Planning & Service Area (PSA) Designation, AAA Operations 9
Plant Food Cooking For Hot Holding 31
Poisonous Or Toxic Materials 33
Posterior Restoration, Dental Restorative Procedures 212
Potentially Hazardous Food, Hot & Cold Holding 32
Poultry Exemption 30
Pregnant Woman With No Other Children, Must Be Included/AFDC-Related Medicaid Budget Unit 45
Pregnant Women & Children (PWC) Codes 224
Premium Or Subscription Charge 185
Prescription Drugs 147, 152
Prescriptions For Nonlegend Products 149, 154
Preventing Contamination From In-Use Utensils, Between Use Storage 31
Preventing Deterioration, Children, Determining Need For NF Care 235
Primary Heating Or Cooling System, Standard Utility Allowance (SUA) 74
Prior Authorization Drugs 148, 149, 154
Prior Authorization, Denturist Policy Guidelines 207, 226
Prior Notification Is Not Required For A Summary Suspension 34
PRO 193
Probability Sampling, Potential Instances Of Fraud, Abuse, Misconduct 268
Procedures For Medicare Cross-Over Claims, Out-Patient Hospital Services 192
Procedures For Medicare Cross-Over Claims, Physician Services 188
Processing Game Animals 31
Program 193, 267
Proof Of Application For An SSN For A Newborn, Food Stamps 84
Property 185
Prosthetic Device 185
Prosthodontics 207, 217
Provider 186
Provider Agreement 186
Provider Agreement Suspension, Suspected Case Of Fraud Or Abuse, Medical Assistance 269
Provider Agreement, Ambulatory Surgical Center 275
Provider Claims, Approved By The Department 141
Provider Coverage Limitations 288
Provider Qualifications For Personal Assistants 286
Provider Qualifications, Adult Developmentally Disabled 243, 257
Provider Qualifications, Medical Assistance 158, 170
Provider Qualifications, Providers Of Waiver Services 137
Provider Records, Three Types 141
Provider Records, Types Of Record Information 262
Provider Reimbursement Manual 186
Provider Reimbursement, Adult Developmentally Disabled Recipients 261
Provider Reimbursement, Criteria Used In Reimbursing Providers Of Waiver Services 141
Provider Responsibility For Notification 288
Provider Responsibility For Notification, Changes In The Recipient's Condition 262
Provider Responsibility For Notification, Notify Case Manager 142
Provider Staff Qualifications 291, 300
Provider Suspension 193
PRWORA 42
Psychology Assistant 186
Psychosocial Rehabilitation (PSR) 296
Psychosocial Rehabilitation (PSR) Services Description 299
Public Notice, Action Taken And Effective Date 194
PWE 42

Q

QMB Dependent Family Member Disregard 101
Qualified Medicare Beneficiary (QMB) 101
Qualified Non-Citizen Child Receiving Federal Foster Care 52, 56, 104, 109
Qualified Non-Citizen Children 87
Qualified Non-Citizen Entering On Or After August 22, 1996 52, 56, 104, 109, 122, 126
Qualified Non-Citizen For At Least Five Years 87
Qualified Non-Citizen Receiving Supplement Security Income (SSI) 105, 109
Qualified Non-Citizen Seniors 87
Qualified Non-Citizens Receiving Disability-Related Assistance 87
Quality Assurance Program 32
Quality Improvement Organization (QIO) 186

R

Real Estate Contract Income 111, 115

Reasons A License May Be Revoked 37
Reasons A Summary Suspension May Be Issued 34
Recipient Eligibility Determination, Waiver Eligibility 140
Recipient's Choice, TSC 166
Recipient's Choice, Whether Or Not They Desire to Receive SC Services 175
Recommended Or Referred By A Physician Or Other Practitioner of the Healing Arts 296
Record Of Expenditures, Business Enterprise Program, Blind & Visually Impaired 20
Record Requirements, EPSDT Service Coordination 176
Record Requirements, IEP 303
Record Requirements, Targeted Case Management For The Mentally Ill 160, 173
Record Requirements, Targeted Developmental Disabilities Service Coordination 167
Records Maintenance 142
Records Maintenance, Regional ACCESS Unit 262
Recoup & Recoupment 267
Recoup And Recoupment 193
Recreational Therapy (Services) 186
Redetermination Process 141
Referred By A Physician Or Other Practitioner Of The Healing Arts 295
Refrigerated Storage Of Medicines 33
Refugees 99
Refugees & Others Fleeing Persecution 87
Refugees, Eligibility For Medicaid For Families/Children 43
Refugees, Food Stamp Program 68
Refusal To Enter Into An Agreement, Medical Assistance 271
Regional Nurse Reviewer (RNR) 186
Regulatory Authority 30
Rehabilitative Services -- Developmental Disabilities Agencies, Medical Assistance 242, 250
Reheating For Hot Holding Ready To Eat Food 31
Reimbursable Services, School Based Programs 291, 296
Reimbursement, Medicaid 172, 238
Reimbursements 91
Removable Prosthodontics 217
Removable Prosthodontics By Codes 207, 217
Removal Of Embargo Tag Or Label 37
Removal Of Records From Provider's Premises 267
Renewal Of License 34
Reporting Requirements, AAA Operations 13
Request For Prior Authorization, Pharmaceutical 148
Required Assessment, Adults, Determining Need For NF Care 234
Required Documentation For Payment 145
Requirement For Plan Of Service And Prior Authorization 250
Requirements For Cooperation With & Notification Of Parents & Agencies 292, 303
Requirements For Determining Recipient Eligibility 140
Requirements For Funding Abortions Under Title XIX 145
Residential Habilitation 133
Residential Habilitation Service Providers 137
Residents Of High Unemployment Areas, JSAP 89
Resource Limit 71, 116
Resource Limit, QMB 101
Resource Limit, SLMB 102
Resources And Change In Household Members 72
Resources Defined, AABD 111, 114
Resources Of Resident 115
Respite Care Service Providers 138
Respite Care Services 134
Restorations By Codes, Dental Restorative Procedures 213
Restriction & Storage Of Medicines 33
Restriction Of Coverage, Physician Services 187
Retirement 70
Retirement & Pension Accounts, Business Enterprise Program, Blind & Visually Impaired 17
Retirement Account Withdrawals, Eligibility For Medicaid For Families/Children 46
Retirement Benefits Paid To Former Spouse Or Third Party 90
Review Of Schedule Of Funds, Business Enterprise Program, Blind & Visually Impaired 20
Revocation Of AAA Designation 9
Revocation Of License 34, 37
Risk Control Plan 36
Room And Board Home Allowance 99
RSDI 42

S

Sanction 193, 267
SAVE 42
SC Provider Agency Qualifications 174
School-Based Health Related Services Provided By Idaho Public School Districts & The Idaho Infant Toddler Program Under The Individuals With Disabilities Education Act (IDEA) 290, 295
Securing & Enforcing Medical Support, Child Support Services 64
Securing Medical Support Information, Child Support Services 64
Self-Direction, Habilitation Services 133
Self-Employment Income, Earned Income 89
Self-Reliance Specialist 141
Service Coordination Individual Provider Staff Qualifications 175
Service Delivery Based On Plan Of Care Or NSA 285
Service Description, Developmental Disabilities Service Coordination 163
Service Descriptions, SC Services 174
Service Detail Reports, IEP 303
Service Limitations 284
Service Limitations, Denturist Policy Guidelines 226
Service Of Notice 38
Service Plan Development And Implementation 169
Service Priority & Appeals, AAA Operations 13
Service Provider Information, Includes Written Documentation Of Each Visit 141
Service Selection, Choice Of

Providers 200
Service Supervision 286
Service Supervision, Adult Developmentally Disabled Recipients 257
Service Supervision, Following A Written Plan 137
Services Delivered Following A Written Plan, Authorized By The Regional Medicaid Unit 136
Services Delivered Prior To Assessment 159, 238
Services Provided, Physician Services 187
Services Provided, Residential Habilitation, Medical Assistance 253
Service-Specific Eligibility 291, 296
Serving An Embargo Order 36
Setting Aside Of Funds, Business Enterprise Program, Blind & Visually Impaired 20
Shelter Costs 73
Siblings, Must Be Included/AFDC-Related Medicaid Budget Unit 45
Sick Leave & Vacation Funds, Business Enterprise Program, Blind & Visually Impaired 17
Skilled Nursing Services 135
Skills Training, Teaching Waiver Recipients 133
Social Security Act 186
Social Security Number Requirement, Eligibility For Medicaid For Families, Children 59
Socialization, General Community Activities 133
Special Cases For Counting Income 72
Specialized Family Home 186
Specialized Medical Equipment And Supplies 135
Specialized Medical Equipment And Supplies, Provider Qualifications 139
Specific Needs, Children, Determining Need For NF Care 235
Specifications For Receiving Potentially Hazardous Food 31
Specified Low Income Medicare Beneficiary (SLMB) 101
Speech/Language Pathology And Audiology Services 186
Sponsored Legal Noncitizens 92
Spouse Can Give Care 92
SRS 42
SSA 42
SSI 42
SSI Number Requirement 114
SSN 42
SSN Requirement Waived 59, 114
SSN Requirement, Food Stamps 83
SSN Requirement, TAFI Eligibility Criteria 129
SSN Requirements For Expedited Food Stamp Service 84
Standard Deduction 66, 73
Standard Utility Allowance (SUA) 73
State Plan 193, 267
Status Of SLMB Group II 102
Stepparent Incapacitated Or Unemployed, Must Be Included/ AFDC-Related Medicaid Budget Unit 45
Steps To Compute Food Stamp Payment 66, 75
Storage Of Embargoed Food 37
Subluxation 186
Summary Suspension Of License 34
Supervision 186
Supervision Required, Children, Determining Need For NF Care 235
Support Income, Eligibility For Medicaid For Families/Children 45
Supported Employment Service Providers 138
Supported Employment Services 134
Suspension Of Payments Pending Investigation, Medical Assistance 269

T

TAFI 42
Tagging Embargoed Food 37
Targeted Case Management For The Mentally Ill 167
Targeted Developmental Disabilities Service Coordination 162
Targeted Developmental Disabilities Service Coordination, Medical Assistance 241, 245
Targeted Service Coordination Agency Qualifications 164
Targeted Service Coordination Agency Qualifications, Medical Assistance 247
Temperature Requirements 31
Temporary Pattern Of Employment 70
Terminated Provider Agreement 271
Terms Of Mandatory Exclusions From The Medicaid Program, Medical Assistance 270
Therapeutic Vitamins 149, 154
Therapy Services 242
Thermal Processing Of Low-Acid Foods 32
Third Party 187
Third Party Payments 91
Title XIX 187
Title XVIII 186
To Apply For A Food License 34
TPL 42
Training & Informational Materials 28
Training Allowances 90
Transfer From Spouse, Assets 118
Transfer To Child, Assets 118
Transitional Medicaid (TM) 49
Transportation 187
Transportation Service Providers Must 138
Transportation Services 134
Traumatic Brain Injury (TBI) Waiver 117
Treatment Services, Developmental Disabilities Centers 251
Trust For Disabled Person 119
Trust Managed By Non-Profit Association For Disabled Person 120
TSC Provider Staff Qualifications 164
TSC Provider Staff Qualifications, Medical Assistance 241, 247
TSC Service Description, Developmental Disabilities, Medical Assistance 245

U

U.S. Citizen 55, 87, 108, 125
U.S. National 87
U.S. National, National Of American Samoa Or Swains Island 55, 108, 125
UIB 42
Undue Hardship, Denying Eligibility 118
Unearned Income, Eligibility For Medicaid For Families/Children 45
Utilization Control (UC) 187
Utilization Control Team (UCT) 187

V

VA 42
Variance Requirements For Food Establishments 32
Varying Payment Cycles 72
Vendor Payment, Dependent Care 92
Vendor Payments, Excluded Income 90
Verification & Documentation Of Correction 36
Verification Of Services Provided, Case Manager Will Verify In Writing 142
Veteran Of The U.S. Armed Forces 55, 87, 108, 125
Victim Of Severe Form Of Trafficking 52, 56, 88, 104, 109, 122, 126
Vitamins 154
Vocational Services 187
Voluntary Quit Or Reduction Of Hours Of Work, Food Stamp/Disqualified Household Members 88
VRS 42

W

Wages Held At The Request Of Employee 72
Wages Held By Employer, Other Than Garnishment And Employee Request 72
Wages Or Salary 89
Waiver Services For Adults With A Traumatic Brain Injury 132
Waiver Services For Adults With Developmental Disabilities & ISSH Waiver Participants 243, 253
Waiver Services Needed 117
Work At Least Eighty Hours Per Month, ABAWD Work Requirement 89
Work Site Problems 70
Written Notice of Summary Suspension 34
Written Report Of Correction 36
Written Violation Correction Report 35