HOUSE HEALTH AND WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2007 Legislative Session

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IDAPA 15 - OFFICE OF THE GOVERNOR

IDAHO COMMISSION ON AGING

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

DOCKET NO. 15-0120-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 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 67-5003, 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 complete text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, page 102.

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

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

DATED this 23rd day of August, 2006.

THIS NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-5003, 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 August 16, 2006.

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: This rulemaking requires Area Agencies on Aging to conduct on-site assessments when providers receive $50,000 or more during a contract year.

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

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the change is being made at the request of the affected parties.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2006.

DATED this 13th day of June, 2006.

Lois S. Bauer, Administrator
Idaho Commission on Aging
3380 Americana Terrace, Ste. 120
P. O. Box 83720
Boise, Idaho 83720-0007
Phone: (208) 334-3833; Fax: (208) 334-3033

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

055. AAA ASSESSMENTS OF PROVIDERS.
Every other year each AAA shall conduct, at a minimum, one (1) on-site assessments of each of its providers that receives fifty thousand dollars ($50,000) or more in combined federal and state funds during a contract year. Such assessments shall comply with the terms of the AAA contract with the ICOA. Such reviews shall be on file for ICOA review. ~~*(3-20-04)*~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.08 - VITAL STATISTICS RULES

DOCKET NO. 16-0208-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 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 39-242, 39-5403, Idaho Code; HB 646 (2006) which modified Section 39-269, Idaho Code; and the Idaho Administrative Procedure Act (APA), Title 67, Chapter 52, 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 complete text of the proposed rule was published in the October 4, 2006, Idaho Administrative Bulletin, Vol. 06-10, pages 210 through 216.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Greg Heitman, Sr. Field Coordinator (Vital Statistics Rules), Division of Health at (208) 334-5986.

DATED this 3rd day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE 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 39-242, 39-5403, and 39-269, Idaho Code; also the Idaho Administrative Procedure Act (APA), Title 67, Chapter 52, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, October 18, 2006.

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:

Vagueness in the law regarding who has the legal authority to request the removal of a body from where it is buried (disinterment) has resulted in confusion between family members as well as between legal agents and families over this matter. To remedy this situation, the Idaho Funeral Service Association introduced a bill (HB 646) in the 2006 legislature that clarified Idaho's disinterment law. The amended law now makes it clear that the person(s) who has the authority to determine the final arrangements for an individual's body at the time of death (Section 54-1142, Idaho Code) is the same person(s) who has the authority to authorize the removal of the body from where it is buried (Section 39-269, Idaho Code), thus eliminating a potential conflict between the two (2) statutes. The rule is being changed to align the Department's disinterment rules with the amended statute and make other minor clarifications as well.

Citations to the Department's "Use and Disclosure" rules were updated to correctly correspond to that chapter of rules, as last amended (2004). Updates were made to the sections at the very beginning and end of the rule to bring them into compliance with the requirements of the Idaho Administrative Procedure Act (APA).

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

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule changes are being made to align with legislation passed during the 2006 legislative session and with recent changes to other Department rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Greg Heitman at (208) 334-5986.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, October 25, 2006.

DATED this 17th day of August, 2006.

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) 334-6558 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
The ~~*State*~~ Idaho Board of Health and Welfare ~~*promulgates rules governing the statewide system of vital records and statistics pursuant to*~~ is authorized under Section 39-242, Idaho Code, to adopt rules that carry out the provisions of Title 39, Chapter~~*s 1,*~~ 2, ~~*and 54,*~~ Idaho Code, related to vital statistics. Under Section 39-5403, Idaho Code, the Board of Health and Welfare is authorized to promulgate rules for reporting and fees related to artificial insemination. ~~*(12-31-91)*~~( )

001. TITLE.
The~~*se*~~ title of these rules ~~*are to be cited as Idaho Department of Health and Welfare Rules,*~~ is IDAPA 16.02.08, "Vital Statistics Rules." ~~*(12-31-91)*~~( )

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for this chapter of rules. ( )

003. ADMINISTRATIVE APPEALS.
Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

004. INCORPORATION BY REFERENCE.
There are no incorporations by reference in this chapter of rules. ( )

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

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

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. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. ( )

05. Internet Website. The Department's internet website is found at http://www.healthandwelfare.idaho.gov. ( )

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

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

00~~2~~7. -- 049. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

200. TRANSMITTAL OF CERTIFICATES AND LOCAL RECORDS -- REPORTS.

01. Transmittal of Certificates of Death and Stillbirth. Certificates of death and stillbirth ~~*shall*~~ must be transmitted by the local registrar to the State Registrar of Vital Statistics within one (1) working day from the date they were received by the local registrar, except when certificates are to be used for expedited copies, in which case they ~~*shall*~~ must be transmitted to the State Registrar on the sixth working day from the date they were received by the local registrar. ~~*(11-20-87)*~~( )

02. Expedited Certified Copies or Certificates of Death or Stillbirth. No certified copies of certificates of death or stillbirth ~~*shall*~~ can be issued by a local deputy state registrar until the registrar is satisfied that the requesting person(s) has "direct and tangible interest" in the certificate as defined in ~~*Idaho Department of Health and Welfare Rules, Subsections 119.01, 119.02, and 119.03,*~~ "~~*Rules Governing the Protection*~~ Use and Disclosure of Department Records," Subsections 011.01 and 011.03 and Section 283. ~~*(12-31-91)*~~( )

03. Transmittal of Certificates of Birth. All certificates of birth ~~*shall*~~ must be transmitted by the local registrar to the State Registrar of Vital Statistics within five (5) working days from the date they are received by the local registrar. ~~*(12-26-83)*~~( )

04. Monthly Summary Report. The local registrar must submit a written report at least once each calendar month on the birth, death, and stillbirth certificates filed with the local registrar. (12-26-83)

a. Form of Monthly Summary Report. The summary report must include, if applicable: (12-26-83)

i. A numerical listing of all original certificates of births, deaths, and stillbirths filed with the local registrar during the month for which the report is made; (12-26-83)

ii. Requests for supplies; (12-26-83)

iii. Violation reports; (12-26-83)

iv. Any other matter the State Registrar of Vital Statistics may request, in writing; and (12-26-83)

v. At a minimum, the fact that no birth, death, or stillbirth certificate was filed in a given month. (12-26-83)

b. Frequency of Reports. These reports must be sent to the Vital Statistics Unit by the fifteenth of the month succeeding the month of registration. (12-26-83)

c. Failure to Report. Failure of a local registrar to make a monthly report for any two (2) calendar months within a six (6) month period is grounds for immediate removal by the State Registrar. (12-26-83)

201. COMPLETION AND CORRECTION OF CERTIFICATES.

01. Correction of Minor Errors on Certificates During the First Year. Except as otherwise provided in these rules, correction of obvious errors or transposition of letters in words of common knowledge, may be made by the State Registrar or an authorized agent within the first year after the date of the event either upon individual observation or query or upon request of any person with a direct and tangible interest as defined in ~~*Idaho Department of Health and Welfare Rules,*~~ IDAPA 16.05.01, ~~*Subsection 119.02,*~~ "~~*Rules Governing The Protection*~~ Use and Disclosure of Department Records," Subsections 011.01 and 011.03, or any person listed in Subsection 201.06.d. of these rules. The method of correction ~~*shall*~~ will be determined by the State Registrar, and ~~*shall not be*~~ is not subject to the requirements of Subsection 201.08 of these rules. When such minor corrections are made by the State Registrar, a notation as to the source of the information, together with the date the change was made and the initials of the authorized agent making the change ~~*shall*~~ must be made on the certificate in such a way as not to become a part of any certification issued. The certificate ~~*shall*~~ must not be marked as amended. ~~*(12-31-91)*~~(____)

02. Amendment of Registrant's Given Names or Surname on Birth Certificates Within the First Year. (12-26-83)

a. Until the registrant's first birthday, given names or surname may be amended upon written notarized request of: (11-20-87)

i. Both parents; (12-26-83)

ii. The mother in the case of a child born out of wedlock and the father's name is not shown on the certificate; (4-5-00)

iii. The father in the case of the death or incapacity of the mother; (12-26-83)

iv. The mother in the case of the death or incapacity of the father; or (12-26-83)

v. The legal guardian or agency having legal custody of the registrant. (12-26-83)

b. The certificate ~~*shall*~~ must be marked as amended. ~~*(12-26-83)*~~( )

03. Amendment of Registrant's Given Name on Birth Certificate After the First Year. (12-26-83)

a. After one (1) year from the date of birth, the provisions of Subsection 201.06 of these rules must be followed to amend the given name if the name was entered in error at the time of the preparation of the birth certificate. ~~*(12-31-91)*~~( )

b. In all other cases, a legal change of name order from a court of competent jurisdiction must be submitted to change a given name after one (1) year. (12-26-83)

04. Addition of Given Names on Birth Certificates. (12-26-83)

a. Until the registrant's seventh birthday, given names, for a child whose birth was recorded without given names, may be added to the certificate upon written notarized request of: (12-26-83)

i. Both parents; (12-26-83)

ii. The mother in the case of a child born out of wedlock and the father's name is not shown on the certificate; (4-5-00)

iii. The father in the case of the death or incapacity of the mother; (12-26-83)

iv. The mother in the case of the death or incapacity of the father; or (12-26-83)

v. The legal guardian or agency having legal custody of the registrant. (12-26-83)

b. The certificate shall be marked as amended. (12-26-83)

c. After the registrant's seventh birthday, the provisions of Subsection 201.06 of these rules must be followed to add a given name. ~~*(12-31-91)*~~()

05. Acknowledgment of Paternity. (12-26-83)

a. Subject to the provisions of Subsection 201.05.b. ~~*below*~~ of these rules, a new certificate of birth ~~*shall*~~ will be prepared by the State Registrar for a child born out of wedlock in this state upon receipt of an affidavit of paternity signed by both parents and a written request by both parents. The child's surname ~~*shall*~~ will be changed on the certificate to that of the father if both parents so request. ~~*(12-26-83)*~~( )

b. If another man is shown as the father of the child on the original certificate, a new certificate may be prepared only when a determination of paternity is made by a court of competent jurisdiction, or following adoption. (12-26-83)

c. The certificate ~~*shall*~~ must not be marked as amended. ~~*(12-26-83)*~~(____)

06. All Other Amendments. Unless otherwise provided in these rules or in Section 39-250, Idaho Code, all other amendments to vital records ~~*shall*~~ must be supported by: ~~*(1-10-86)*~~(____)

a. An affidavit setting forth: (12-26-83)

i. Information to identify the certificate; (12-26-83)

ii. The incorrect data as it is listed on the certificate; and ~~*(12-26-83)*~~(____)

iii. The correct data as it should appear. (12-26-83)

b. If one (1) year has elapsed since the date the event occurred, one (1) or more items of documentary evidence which support the alleged facts and which were established at least five (5) years prior to the date of application for amendment or within seven (7) years of the date of the event. (12-26-83)

c. Any item of a medical nature ~~*shall*~~ can be amended only upon receipt of an affidavit from the person certifying such item, except that queries originating in the vital statistics office and subsequently completed and signed by the certifier may be used to complete or modify the reported cause of death. The State Registrar may require documentary evidence to substantiate the requested amendment. ~~*(9-1-84)*~~(____)

d. Applications to amend a specific vital record will be accepted as follows: (12-26-83)

i. An application to amend a birth certificate may only be made by one (1) or both of the parents, the legal guardian, the registrant if eighteen (18) years of age or older, or the individual responsible for filing the certificate. (12-26-83)

ii. An application to amend a death certificate may only be made by the informant, the next of kin, the funeral director or person acting as such who signed the death certificate, or the certifying physician or coroner. (12-26-83)

iii. An application to amend a stillbirth certificate may only be made by a person listed in Subsections 201.06.d.i. or 201.06.d.ii. ~~*above*~~ of these rules. ~~*(12-31-91)*~~(____)

iv. An application to amend a marriage or divorce certificate may only be made by the custodian of the official record from which the certificate was prepared, either of the parties to the marriage or divorce, or the individual responsible for filing the certificate. (12-26-83)

e. The State Registrar ~~*shall*~~ will evaluate the evidence submitted in support of any amendment, or require additional documentation. The State Registrar's decision and determination ~~*shall*~~ will be based upon serving the objectives of the vital statistics statutes and the best interests of the public. In the event the application is rejected or additional information is required, the State Registrar ~~*shall*~~ must advise the applicant of the reason for the action and the

right to appeal pursuant to Section 39-250(d), Idaho Code. ~~(12-31-91)~~(____)

07. Amendment of the Same Item More Than Once. Once an item is amended on a vital record, that item ~~*shall*~~ can not be amended again except upon receipt of a court order from an Idaho court of competent jurisdiction. ~~(12-26-83)~~(____)

08. Methods of Amending Certificates. (12-26-83)

a. Certificates of birth, death, stillbirth, marriage, and divorce may only be amended by the State Registrar as follows: (12-26-83)

i. Preparing a new certificate showing the correct information when the State Registrar deems that the nature of the amendment so requires. The new certificate may be prepared on the form used for registering current events at the time of amendment. Except as provided elsewhere in these rules, the item number of the entry that was amended ~~*shall*~~ must be identified on the new certificate. In every case, except as provided elsewhere in these rules or the Idaho Code, the new certificate ~~*shall*~~ must show the date the amendment was made and be given the same state file number as the existing certificate. Signatures appearing on the existing certificate ~~*shall*~~ must be typed on the new certificate. ~~(12-26-83)~~(____)

ii. Completing the item in any case where the item was left blank on the existing certificate. (12-26-83)

iii. Drawing a single line through the item to be amended and inserting the correct data immediately above or to the side. The line drawn through the original entry ~~*shall*~~ must not obliterate such entry. ~~(12-26-83)~~(____)

iv. A certificate of birth amended ~~*pursuant to*~~ in accordance with the provisions of Section 39-250(c), Idaho Code, ~~*shall*~~ must be amended as prescribed in Subsection 201.08.a.iii. ~~*above*~~ of these rules. The fact that the name was changed ~~*pursuant to*~~ in accordance with a court order ~~*shall*~~ must be stated on the certificate. ~~(12-31-91)~~(____)

b. Unless prohibited by statute or rule, there ~~*shall*~~ must be inserted on the face of the certificate the date the amendment was made and the initials of the person making the change; the certificate ~~*shall*~~ must be marked as amended. ~~(12-26-83)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

851. AUTHORIZATION FOR DISINTERMENT AND REINTERMENT.

01. ~~***Authorization***~~ **Disinterment and Reinterment of a Dead Body or Fetus**. ~~*A*~~ Upon receipt of a notarized application, or an order of a court of record of this state, the State Registrar will issue a permit for the disinterment and reinterment of a dead body or fetus ~~*shall be issued by the State Registrar upon receipt of a notarized application/authorization signed by the next of kin and the person who is in charge of the disinterment, or upon receipt of an order of a court of*~~

~~record of this state directing such disinterment, or upon notarized written application of any person authorized by Section 39-269, Idaho Code, to request a special disinterment permit for legal purposes~~. The permit will be issued only to the mortician who is identified on the application or order as the mortician in charge of the disinterment. The application for the permit must be signed by the applicant and the mortician in charge of the disinterment. The applicant for the permit must be either: ~~(12-26-83)~~( )

a. The person or persons who have the highest authority under the provisions of Section 54-1142, Idaho Code; or ( )

b. A person authorized by Section 39-269, Idaho Code, to request a special disinterment for legal purposes, in which case the application must state facts showing that the ends of justice require disinterment. ( )

02. Mass Disinterment and Reinterment. Upon receipt of a ~~court order, a signed and~~ notarized ~~permission of the next of kin of all decedents, or a signed and notarized application for disinterment for legal purposes~~ application, or an order of a court of record of this state, the State Registrar may issue ~~one (1)~~ a single permit for the disinterment and reinterment of all remains included in a mass disinterment~~, provided that, insofar as possible, the remains of each body be identified and the place of disinterment and reinterment specified~~. The permit will be issued only to the mortician who is identified on the application or order as the mortician in charge of the disinterment. The application or order for the permit must identify the remains of each body to the extent possible and specify the place of disinterment and reinterment. The application for the permit must be signed by the applicant and the mortician in charge of the disinterment. The applicant for the permit must be either: ~~(12-26-83)~~( )

a. The person or persons who have the highest authority under the provisions of Section 54-1142, Idaho Code, for each of the deceased; or ( )

b. A person authorized by Section 39-269, Idaho Code, to request a special disinterment for legal purposes, in which case the application must state facts showing that the ends of justice require disinterment. ( )

03. Nature of Permit. The authorization issued in accordance with the statutes and ~~regulations~~ rules governing disinterment ~~shall be~~ is permission for disinterment, transportation and reinterment. ~~(12-26-83)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

901. -- 99~~5~~9. (RESERVED).

~~***996. ADMINISTRATIVE PROVISIONS.***~~
~~*Contested case appeals shall be governed by Section 39-250 (d), Idaho Code, and Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Sections 000, et seq., "Rules Governing Contested Cases Proceedings and Declaratory Rulings".* (12-31-91)~~

997. CONFIDENTIALITY OF RECORDS.
The disclosure of vital records is governed by Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records". *(12-26-83)*

998. INCLUSIVE GENDER AND NUMBER.
For the purposes of these rules, words used in the masculine gender include the feminine, or vice versa, where appropriate. *(12-31-91)*

999. SEVERABILITY.
Idaho Department of Health and Welfare Rules, IDAPA 16.02.08, "Vital Statistics Rules," are severable. If any rule, or part thereof, or the application of such rule to any person or circumstance is declared invalid, that invalidity does not affect the validity of any remaining portion of this chapter. *(12-26-83)*

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.15 - IMMUNIZATION REQUIREMENTS FOR IDAHO SCHOOL CHILDREN

DOCKET NO. 16-0215-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 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 39-4801, 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 complete text of the proposed rule was published in the September 6, 2006, Idaho Administrative Bulletin, Vol. 06-9, page 81 through 83.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Dieuwke Spencer at (208) 334-5930.

DATED this 3rd day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 39-4801, 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 September 20, 2006.

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

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

These changes to the current school immunization rule are due to concerns raised by physicians that the current school immunization rules do not complement the current recommended Advisory Committee on Immunization Practices (ACIP) immunization schedule. The intent of this proposed rule change is to develop requirements that meet physician, school and public health priorities of protecting children.

The proposed changes include altering the fifth Diphtheria, Tetanus, and acellular Pertussis (DTaP) and second Measles, Mumps and Rubella (MMR) requirements to make sure they conform to the Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule, while meeting the needs of physicians, schools and public health. The term "preschool" was deleted from this rule to allow the physician to choose the most appropriate interval for the child's immunization schedule within the ACIP recommendations.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. N/A - There is no fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because concerns expressed by physicians regarding the current school immunization rules are being addressed in this docket.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dieuwke Spencer at 334-5930.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2006.

DATED this 27th day of July, 2006.

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) 334-6558 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

001. TITLE AND SCOPE.

01. Title. The title of this chapter is, IDAPA 16.02.15, "Immunization Requirements for Idaho School Children." (4-6-05)

02. Scope. These rules contain the legal requirements for the administration of an immunization program for children enrolled in grades ~~*preschool,*~~ kindergarten through twelve (12) of any Idaho public, private, or parochial school. ~~*(10-13-92)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

01. ACIP. The Center for Disease Control's Advisory Committee on Immunization Practices. (4-6-05)

02. Admission. Enrollment of a child who is admitted for the first time at the commencement of or during the regular school term to public, private or parochial school. (4-6-05)

03. Child. A minor who is enrolled in ~~*preschool,*~~ kindergarten through grade twelve (12) in any Idaho public, private, or parochial school. ~~*(10-13-92)*~~(____)

04. Department. Idaho Department of Health and Welfare. (10-13-92)

05. Laboratory Proof. A certificate from a licensed medical laboratory stating the type of test performed, the date of each test, and the results. Tests performed must meet the requirements of IDAPA 16.02.06, "Rules Governing Quality Assurance for Idaho Clinical Laboratories". (4-6-05)

06. Parent, Custodian or Guardian. The legal parent, custodian or guardian of a child or those with limited power of attorney for the temporary care or custody of a minor child. (4-6-05)

07. Pertussis. An infectious agent, *Bordetella pertussis*, that causes the disease commonly known as whooping cough. (4-6-05)

08. Physician. A medical doctor or osteopath licensed by the Idaho State Board of Medicine, or by a similar body in another state or jurisdiction within the United States. (4-6-05)

09. Physician's Representative. Any person appointed by, or vested with the

authority to act on behalf of a physician in matters concerning health. (8-15-79)

10. Private or Parochial School. Any Idaho school maintained by an individual, organization or corporation, not at public expense, and open only to children selected and admitted by the individual, organization or corporation, or to children of a certain class or possessing certain qualifications, which may or may not charge tuition fees. (1-25-79)

11. Public School. Any Idaho school maintained at the public expense and open to all children within a given district, including those responsible for the education and training of exceptional children or those schools specially chartered. (1-25-79)

12. School Authority. An authorized representative designated by the Board of Trustees of a public school or a person or body designated to act on behalf of the governing body of a private or parochial school. (8-15-79)

011. -- 099. (RESERVED).

100. IMMUNIZATION PROGRAM.
All immunizations, listed in Subsections 100.01 through 100.04 of these rules, are required of children ~~*who are to attend preschool, kindergarten through grade twelve (12) in*~~ upon admission to kindergarten through grade twelve (12) of any Idaho public, private, or parochial school. Immunizations will be recognized if administered according to the "General Recommendations on Immunizations" established by the ACIP or their equivalent. These recommendations are available from the Department. ~~*(4-6-05)*~~(____)

01. Measles, ~~*Rubella, and*~~ Mumps and Rubella (MMR). Two (2) doses of Measles, ~~*Rubella and*~~ Mumps and Rubella (MMR) or Measles, Mumps, Rubella and Varicella (MMRV) vaccine administered to the child according to ACIP recommendations for children ~~*entering preschool or kindergarten*~~ on or after the beginning of the 2005 school term. ~~*(4-6-05)*~~(____)

02. ~~*Diphtheria, Tetanus, A-Cellular Pertussis (DTaP), Diphtheria, Tetanus (DT Pediatric) or Tetanus, Diphtheria (Td)*~~. ~~*Any combination of five (5) doses of DTaP (Diphtheria, Tetanus, a-cellular Pertussis), DT (Diphtheria, Tetanus) or Td (Tetanus, Diphtheria) vaccine are required for all children entering Preschool or Kindergarten on or after the beginning of the 2005 school term, unless fewer doses are medically recommended. See Section 110 of these rules. If the fourth dose was administered on or after the child's fourth birthday, the fifth dose is not needed,*~~ **Diphtheria, Tetanus, and Pertussis**. Any combination of five (5) doses of the following vaccines for Diphtheria, Tetanus, and Pertussis administered to the child according to ACIP recommendations on or after the beginning of the 2005 school term, unless fewer doses are medically recommended. See Section 110 of these rules for exemptions to the immunization requirements. If the fourth dose was administered on or after the child's fourth birthday, the fifth dose is not needed. The approved combinations are: ~~*(4-6-05)*~~(____)

a. Diphtheria, Tetanus, and acellular Pertussis (DTaP - Pediatric); (____)

b. Diphtheria, Tetanus and Pertussis (DTP); (____)

c. Tetanus, Diphtheria and acellular Pertussis (Tdap - Adolescent); (____)

d. Diphtheria, Tetanus (DT - Pediatric); and ( )

e. Tetanus, Diphtheria (Td - Adolescent). ( )

03. Polio. Three (3) doses of Polio vaccine, unless fewer doses are medically recommended. See Section 110 of these rules for exemptions to the immunization requirements. ~~(4-6-05)~~( )

04. Hepatitis B. Three (3) doses of Hepatitis B vaccine administered to children born after November 22, 1991, unless fewer doses are medically recommended. See Section 110 of these rules for exemptions to the immunization requirements. ~~(4-6-05)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

150. ENFORCEMENT OF IMMUNIZATION REQUIREMENT.

01. Noncompliance. Any child not in compliance with this chapter upon admission ~~*in preschool, kindergarten through grade twelve (12) in*~~ to any Idaho public, private or parochial school, will be denied attendance by school authorities. ~~(4-6-05)~~( )

02. Length of Exclusion. Any child denied attendance in accordance with Subsection 150.01 of these rules, will not be allowed to attend any Idaho public, private or parochial school until they are in compliance with the requirements of this chapter. (4-6-05)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0601 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 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, 56-209, 56-236, 56-237, 56-238, 56-239, 56-240, 56-242, 56-250, and 56-255, Idaho Code. These rule changes are being made to bring this chapter of rules into compliance with HB 776 (2006) - "Idaho Medicaid Simplification Act," SB1417 (2006), and HCR 50 (2006).

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 complete text of the proposed rule was published in the August 2, 2006, Idaho Administrative Bulletin, Vol. 06-8, page 103.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Linda Palmer at (208) 334-5845.

DATED this 15th day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are July 1, 2006.

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 Sections 56-202, 56-203, 56-209, 56-236, 56-237, 56-238, 56-239, 56-240, 56-242, 56-250, and 56-255, Idaho Code. These rule changes are being made to bring this chapter of rules into compliance with HB 776 (2006) - "Idaho Medicaid Simplification Act," SB1417 (2006), and HCR 50 (2006).

DEPARTMENT OF HEALTH & WELFARE ***Docket No. 16-0301-0601***
Eligibility for Health Care Assistance for Families & Children ***PENDING RULE***

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

Date:	**Wednesday, August 16, 2006**	**Thursday, August 17, 2006**	**Tuesday, August 22, 2006**
Time:	**7:00 p.m.**	**7:00 p.m.**	**7:00 p.m.**
Place:	**Idaho Falls Public Library** **457 Broadway** **Idaho Falls, ID** **Phone: (208) 612-8455**	**Coeur d'Alene Inn** **Hayden Conference Room** **506 W Appleway Ave.** **Coeur d'Alene, ID**	**DHW - Region IV Office** **1720 Westgate Dr.** **Suite D, Room 119** **Boise, 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 nontechnical explanation of the substance and purpose of the proposed rulemaking: This entire chapter of rules is being repealed as part of the process for implementing the Idaho Medicaid Simplification Act (2006). The text of the rewritten chapter appears under Docket No. 16-0301-0602 that is being published simultaneously with this docket and has the same effective date.

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

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes to rule are being made to implement legislation passed during the 2006 legislative session.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Linda Palmer at (208) 334-5845.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, August 23, 2006.

DATED this 29th day of June, 2006.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
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IDAPA 16.03.01 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0602 (CHAPTER REWRITE)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is July 1, 2006 and October 1, 2006. This pending rule has been adopted by the agency and is now pending review by the 2007 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, 56-209, 56-236, 56-237, 56-238, 56-239, 56-240, 56-242, 56-250, 56-253, 56-255, and 56-257, Idaho Code. These rule changes are being made to bring this chapter of rules into compliance with HB 776 (2006) - "Idaho Medicaid Simplification Act," SB1417, and HCR 50 (2006).

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the 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 amendments to these rules are the result of comments from the Centers for Medicare and Medicaid Services (CMS) on the Deficit Reduction Act (DRA) of 2005, the Legislative Services Office, public hearings and written comments during the comment period, and from within the Department. The following are specific changes made to the temporary and proposed rules:

1. **Section 000 - Two additional legal authority cites were added as recommended by the Legislative Service Office.**
2. **Section 010 - A definition was added for "Children's Access Card", the definition for "Cost-Sharing" was changed to align with Idaho Code at the recommendation of the Legislative Service Office.**
3. **Section 011 - The definition for "Participant" was changed to align with Idaho Code and the definition for "Premium Assistance" was deleted.**
4. **Section 221 - This section was deleted and re-written based on new guidelines from CMS for U.S. Citizenship and Identify Documentation Requirements. Sections 222 - 228 were added that provides the different levels of citizen documentation required by the DRA of 2005 to prove U.S. citizenship and identity.**
5. **Section 420 - The word "child" was added to this section based on federal regulation that states that an increase in child support income needs to be included in rule.**
6. **Section 523 - This section was revised to align with the Idaho State Medicaid Plan and addresses a child enrolled in a creditable health insurance plan or is a dependent**

of a state employee.

7. **Sections 560-562 were added due to a lack of federal support, the age and income guidelines for the Children's Access Card program must be corrected. This change also aligns the rule with IDAPA 16.03.16 "Premium Assistance."**

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 from the proposed text are printed in this bulletin. The original text of the temporary and proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 104 through 132.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Linda Palmer at (208) 334-5845.

DATED this 15th day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are July 1, 2006 and October 1, 2006.

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 Sections 56-202, 56-203, 56-209, 56-236, 56-237, 56-238, 56-239, 56-240, 56-242, 56-250, and 56-255, Idaho Code. These rule changes are being made to bring this chapter of rules into compliance with HB 776 (2006) - "Idaho Medicaid Simplification Act," SB1417 (2006), and HCR 50 (2006).

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

Date:	**Wednesday, August 16, 2006**	**Thursday, August 17, 2006**	**Tuesday, August 22, 2006**
Time:	**7:00 p.m.**	**7:00 p.m.**	**7:00 p.m.**
Place:	**Idaho Falls Public Library** **457 Broadway** **Idaho Falls, ID** **Phone: (208) 612-8455**	**Coeur d'Alene Inn** **Hayden Conference Room** **506 W Appleway Ave.** **Coeur d'Alene, ID**	**DHW - Region IV Office** **1720 Westgate Dr.** **Suite D, Room 119** **Boise, 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.

DEPARTMENT OF HEALTH & WELFARE ***Docket No. 16-0301-0602***
Eligibility for Health Care Assistance for Families & Children ***PENDING RULE***

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

At the direction of the Governor and the Idaho Legislature, the Department of Health and Welfare is proposing rule changes to modernize Idaho's Medicaid Program. The purpose of this project is to improve health outcomes for needy Idahoans while balancing access, quality, and cost containment.

This rewrite of IDAPA 16.03.01 reflects the legislative intent in the Idaho Medicaid Simplification Act that authorizes the Department to restructure the Idaho Medicaid program in order to achieve improved health outcomes for Medicaid participants and slow the rate of growth in Medicaid costs.

The proposed content for the chapter rewrite:

1. **Simplifies the eligibility process for Low Income Children and Working-Age Adults and Persons with Disabilities or Special Health Needs, based on the participants' health needs determined by a health assessment;**
2. **Improves clinical and financial effectiveness;**
3. **Promotes equitable participation among eligible members;**
4. **Has program structures that connect need, eligibility, benefits and desirable outcomes;**
5. **Has benefits that match identified health needs of participants and that are based on health care "best practices";**
6. **Provides Idaho families more ways to make choices about their health care;**
7. **Increase access to private health insurance; and**
8. **Improves accuracy and timeliness of benefit determinations.**

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

FEE SUMMARY: There is no fee or charge being imposed or increased in this docket. N/A

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes to rule are being made to implement legislation passed during the 2006 legislative session.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Linda Palmer at (208) 334-5845.

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 Wednesday, August 23,

2006.

DATED this 29th day of June, 2006.

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) 334-6558 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16
TITLE 03
CHAPTER 01

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

000. LEGAL AUTHORITY.
In accordance with Sections 56-202, 56-203, 56-209, 56-236, 56-237, 56-238, 56-239, 56-240, 56-242, 56-250, ~~*and*~~ *56-253,* 56-255, *and 56-257,* Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules for the administration of Title XIX of the Social Security Act (Medicaid), Title XXI of the Social Security Act, and the Premium Assistance program. ~~*(7-1-06)T*~~(7-1-06)T

001. TITLE AND SCOPE.

01. Title. These rules will be cited as IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." (7-1-06)T

02. Scope. These rules provide standards for issuing coverage for Title XIX and Title XXI of the Social Security Act as well as Premium Assistance coverage to children. (7-1-06)T

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency has written statements that 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. (7-1-06)T

003. ADMINISTRATIVE APPEALS.
All administrative appeals are governed by provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (7-1-06)T

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference into these rules. (7-1-06)T

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

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (7-1-06)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (7-1-06)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (7-1-06)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (7-1-06)T

05. Internet Website. The Department's internet website is found at www.healthandwelfare.idaho.gov. (7-1-06)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS.

01. Confidential Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (7-1-06)T

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (7-1-06)T

007. -- 009. (RESERVED).

010. DEFINITIONS (A THROUGH L).
For the purposes of these rules the following terms are used as defined below: (7-1-06)T

01. Adult. Any individual who has passed the month of his nineteenth birthday. (7-1-06)T

02. AFDC. Aid to Families with Dependent Children, the cash assistance program for families and children in effect through June 30, 1997. (7-1-06)T

03. Application Date. The date the Application for Assistance (AFA) is received by the Department in a local office or the date the application is postmarked, if mailed. (7-1-06)T

04. Budget Unit. A budget unit is a person or group of persons who are relatives of specified degree and live in the same home with a Medicaid-eligible dependent child. (7-1-06)T

05. Child. Any individual from birth through the end of the month of his nineteenth birthday. (7-1-06)T

***06. Children's Access Card**. The Children's Access Card is a premium assistance program that pays a premium subsidy toward a private health insurance plan for children who choose to participate in the program rather than receive benefits under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (7-1-06)T*

0~~6~~7. Cost-Sharing. ~~*A payment the participant is required to make toward the cost of their health care.*~~ *A participant payment for a portion of Medicaid service costs such as deductibles, coinsurance or co-payment amounts.* ~~*(10-1-06)T*~~(10-1-06)T

0~~7~~8. Creditable Health Insurance. Creditable health insurance is coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits. (7-1-06)T

0~~8~~9. Department. The Idaho Department of Health and Welfare. (7-1-06)T

~~09~~10. Disenrollment. The end of an individual's participation in a health insurance program. (7-1-06)T

1~~0~~1. Eligibility. The determination of whether or not an individual is eligible for health care benefits. (7-1-06)T

1~~1~~2. Enrollment. The process of adding eligible individuals to a health care benefit. (7-1-06)T

1~~2~~3. Extended Medicaid. Extended Medicaid is medical assistance for a parent or relative caretaker who becomes ineligible for Title XIX Medicaid due to an increase in child or spousal support payments. (7-1-06)T

1~~3~~4. Family Size. Family size is the number of people living in the same home as the child. This includes relatives and other optional household members. (7-1-06)T

1~~4~~5. Federal Poverty Guidelines (FPG). The federal poverty guidelines issued annually by the Department of Health and Human Services (HHS). (7-1-06)T

1~~5~~6. Health Assessment. Health Assessment is an examination performed by a primary care provider in order to determine the appropriate health plan for a Medicaid-eligible individual. (7-1-06)T

1~~6~~7. Health Care Assistance (HCA). Title XIX, Title XXI, or Premium Assistance benefits granted by the Department for persons or families under the authority of Title 56, Chapter 2, Idaho Code. (7-1-06)T

1~~7~~8. Health Insurance Premium Program (HIPP). The Premium Assistance program in which Title XIX and Title XXI participants may participate. (7-1-06)T

1~~8~~9. Health Plan. A set of health services paid for by Idaho Medicaid. (7-1-06)T

~~19~~20. Health Questionnaire. A tool used to assist Health and Welfare staff in determining the correct Health Plan for the Medicaid applicant. (7-1-06)T

2~~0~~1. HUD. The U.S. Department of Housing and Urban Development. (7-1-06)T

2~~1~~2. Liquid Assets. Liquid assets include such things as cash, bank accounts, proceeds from the sale of a resource, stocks, bonds, mutual funds, promissory notes, mortgages, tax refunds, settlement of damage claims, trust funds, and other financial instruments that can be converted into cash. (7-1-06)T

2~~2~~3. Low Income Pregnant Woman. Medical assistance for a pregnant woman that is limited to pregnancy-related services for the period of the pregnancy and sixty (60) days after the pregnancy ends. (7-1-06)T

011. DEFINITIONS (M THROUGH Z).
For the purposes of these rules the following terms are used as defined below: (7-1-06)T

01. Participant. A person ~~*who is applying for or receiving Title XIX, Title XXI, or Premium Assistance*~~ *eligible for, and enrolled in, the Idaho medical assistance program*. ~~*(7-1-06)T*~~(7-1-06)T

02. Premium. A regular, periodic charge or payment for health coverage as set forth in IDAPA 16.03.16, "Premium Assistance." (7-1-06)T

~~***03. Premium Assistance**. The partial or total premium paid to an insurance company or employer by the State to supplement the cost of enrolling eligible individuals in a health insurance plan.* *(7-1-06)T*~~

0~~4~~3. Relative of Specified Degree. Relatives of specified degree include: father, mother, (natural or adoptive), child, grandfather or grandmother, brother or sister, stepfather or stepmother, stepbrother or stepsister, aunt or uncle, first cousin, first cousin once removed, niece, nephew, and persons of preceding generations denoted by grand, great or great-great. (7-1-06)T

0~~5~~4. SSI. Supplemental Security Income. (7-1-06)T

0~~6~~5. SSN. Social Security Number. (7-1-06)T

0~~7~~6. State. The state of Idaho. (7-1-06)T

0~~8~~7. **TAFI**. Temporary Assistance for Families in Idaho. (7-1-06)T

0~~9~~8. **TANF**. Temporary Assistance to Needy Families. (7-1-06)T

~~1~~09. **Title XIX**. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the States. This program pays for medical assistance for certain individuals and families with low income and limited resources. (7-1-06)T

1~~1~~0. **Title XXI**. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), is a federal and state partnership similar to Medicaid, that expands health insurance to targeted, low- income children. (7-1-06)T

1~~2~~1. **Transitional Medicaid**. Medical assistance for families who become ineligible for AFDC-related Title XIX Medicaid due to an increase in earned income or loss of income disregards. (7-1-06)T

1~~3~~2. **Working Day.** A calendar day in which the regular hours of Department activity occur. Weekends and State holidays are not considered working days. (7-1-06)T

012. -- 099. (RESERVED).

APPLICATION REQUIREMENTS
(Sections 100 Through 199)

100. PARTICIPANT RIGHTS.
The participant has rights protected by federal and state laws and Department rules. The Department must inform participants of the following rights during the application process and eligibility reviews: (7-1-06)T

01. Right to Apply. Any person has the right to apply for Health Care Assistance programs. Applications must be in writing on forms provided by the Department. (7-1-06)T

02. Right to Hearing. Any participant can request a hearing to contest a Department decision in accordance with IDAPA 16.05.03. "Contested Case Proceedings and Declaratory Rules." (7-1-06)T

03. Right to Request Reinstatement of Benefits. Any participant has the right to request reinstatement of benefits until a hearing decision is made if the requests for the hearing and for the reinstatement are made within ten (10) days of the mailing of the notice of action. (7-1-06)T

04. Civil Rights. Participants have civil rights under the U.S. and Idaho Constitutions, the Social Security Act, Title IV of the Civil Rights Act of 1964, the Rehabilitation Act of 1973 contained in Title 29 of the U.S. Code, and all other relevant parts of federal and state laws. (7-1-06)T

101. -- 109. (RESERVED).

110. APPLICATION FOR HEALTH CARE ASSISTANCE.
The application form must be complete and signed by the participant or authorized representative. By signing the application form, the participant or authorized representative agrees, under penalty of perjury, that statements made on the application are truthful. (7-1-06)T

111. -- 119. (RESERVED).

120. COLLATERAL CONTACTS.
A participant's signature on the application is his consent for the Department to contact collateral sources for verification of eligibility requirements. (7-1-06)T

121. -- 129. (RESERVED).

130. APPLICATION TIME LIMITS.
Each application must be processed within forty-five (45) days, unless prevented by events beyond the Department's control. (7-1-06)T

131. -- 139. (RESERVED).

140. ELIGIBILITY EFFECTIVE DATES.
Title XIX and Title XXI coverage begins the first day of the application month. Premium Assistance begins the first day of the month that private insurance coverage begins. (7-1-06)T

141. -- 149. (RESERVED).

150. RETROACTIVE MEDICAL ASSISTANCE ELIGIBILITY.
Title XIX and Title XXI can begin up to three (3) calendar months before the application month if the participant is eligible during the prior period. Coverage is provided if services that can be paid by Medicaid were received in the prior period. Participants who are found to be eligible for Premium Assistance are eligible for retroactive medical assistance if they meet all of the eligibility criteria for Title XIX or Title XXI in the prior period. (7-1-06)T

151. -- 199. (RESERVED).

NON-FINANCIAL REQUIREMENTS
(Sections 200 Through 299)

200. NON-FINANCIAL CRITERIA FOR DETERMINING ELIGIBILITY.
Non-financial criteria are conditions of eligibility, other than income and resources, that must be met before Health Care Assistance can be authorized. (7-1-06)T

201. -- 209. (RESERVED).

210. RESIDENCY.
The participant must voluntarily live in Idaho and have no immediate intention of leaving. (7-1-06)T

211. -- 219. (RESERVED).

220. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible, an individual must be a member of one (1) of the following groups: (7-1-06)T

01. U.S. Citizen. A U.S. Citizen; (7-1-06)T

02. U.S. National, National of American Samoa or Swain's Island. A U. S. national, or a national of American Samoa or Swain's Island. (7-1-06)T

03. Child Born Outside the U.S. A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: (7-1-06)T

a. At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; (7-1-06)T

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen; (7-1-06)T

c. The child is under eighteen (18) years of age; (7-1-06)T

d. The child is a lawful permanent resident; and (7-1-06)T

e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent.(7-1-06)T

04. 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; (7-1-06)T

05. Veteran of the U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who were 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; (7-1-06)T

06. Non-Citizen Entering the U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, who is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c), who remained continuously present in the U.S. until he became a qualified non-citizen; (7-1-06)

07. Non-Citizen Entering On or After August 22, 1996. A non-citizen who entered the U.S. on or after August 22, 1996, and who is: (7-1-06)T

a. 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; (7-1-06)T

b. 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; (7-1-06)T

c. 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; (7-1-06)T

d. 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 (7-1-06)T

e. A Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act under Section 501(e) of P.L. 96-422 (1980), and can be eligible for seven (7) years from their date of entry; (7-1-06)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), who entered the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years; (7-1-06)T

09. American Indian Born in Canada. An American Indian born in Canada, under 8 U.S.C. 1359; (7-1-06)T

10. American Indian Born Outside the U.S. An American Indian born outside of the U.S., who is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e); (7-1-06)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; and (7-1-06)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: (7-1-06)T

a. Is under the age of eighteen (18) years; or (7-1-06)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 (7-1-06)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 (7-1-06)T

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (7-1-06)T

221. U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.
~~*To be eligible for Medicaid, an individual must provide documentation of identity and U.S. citizenship. The following are acceptable forms of documentation:*~~ *Any individual who participates in a Medicaid funded program must provide documentation of U.S. citizenship and identity unless he has otherwise met the requirements under Section 225 of this rule. The individual must provide the Department with the most reliable document that is available. Documents must be originals or copies certified by the issuing agency. Copies of originals or notarized copies cannot be accepted. The Department will accept original documents in person, by mail, or through a guardian or authorized representative.* ~~*(7-1-06)T*~~(10-1-06)T

~~***01. Documents Accepted as Proof of Both U.S. Citizenship and Identity****. The following documents may be accepted as proof of both U.S. citizenship and identity.* *(7-1-06)T*~~

~~***a.*** *A U.S. passport;* *(7-1-06)T*~~

~~***b.*** *A Certificate of Naturalization (DHS Forms N-550 or N-570);* *(7-1-06)T*~~

~~***c.*** *A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561); or* *(7-1-06)T*~~

~~***02. Documents Accepted as Proof of U.S. Citizenship, But Not Identity****. The following documents may be accepted as proof of U.S. citizenship only. They are not proof of identity and must be used in combination with at least one (1) document listed in Subsection 221.03 of this rule to establish both citizenship and identity.* *(7-1-06)T*~~

~~***a.*** *A U.S. birth certificate;* *(7-1-06)T*~~

~~***b.*** *A Report of Birth Abroad of a U.S. Citizen (Form FS-545 or DS-1350);* *(7-1-06)T*~~

~~***c.*** *A U.S. Citizen I.D. card (DHS Form I-197);* *(7-1-06)T*~~

~~***d.*** *A hospital record of birth issued at the time of birth in one (1) of the fifty (50) states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands. If the person was born to foreign diplomats residing in one (1) of the preceding jurisdictions of the U.S., he is not a citizen of the United States;* *(7-1-06)T*~~

~~***e.*** *A Northern Mariana Identification Card issued by the Immigration and Naturalization Service (INS) to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 3, 1986;* *(7-1-06)T*~~

~~***f.*** *An American Indian Card issued by the Department of Homeland Security;* *(7-1-06)T*~~

~~***g.*** *Information from a primary source such as the State Data Exchange (SDX) or birth confirmations from Vital Statistics; or* *(7-1-06)T*~~

~~***03. Documents Accepted as Proof of Identity, but Not Citizenship****. The following*~~

~~documents may be accepted as proof of identity. They are not proof of citizenship and must be used in combination with at least one (1) document listed in Subsection 221.02 of this rule to establish both citizenship and identity. (7-1-06)T~~

~~a. A current state driver's license bearing the individual's picture; (7-1-06)T~~

~~b. A state-issued identity card issued to a non-driver bearing the individual's picture, for which the state required proof of identity as a condition of issuing the identity document. (7-1-06)T~~

222. LEVELS OF CITIZENSHIP DOCUMENTATION.

01. Documents Accepted as Primary Level Proof of Both U.S. Citizenship and Identity. The following documents are accepted as the primary level of proof of both U.S. citizenship and identity: (10-1-06)T

a. A U.S. passport; (10-1-06)T

b. A Certificate of Naturalization, DHS Forms N-550 or N-570; or (10-1-06)T

c. A Certificate of U.S. Citizenship, DHS Forms N-560 or N-561. (10-1-06)T

02. Documents Accepted as Secondary Level Proof of U.S. Citizenship but Not Identity. The following documents are accepted as proof of U.S. citizenship if the proof in Subsection 222.01 is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsection 222.05 or Section 223 of these rules to establish both citizenship and identity. (10-1-06)T

a. A U.S. birth certificate that shows the individual was born in one (1) of the following: (10-1-06)T

i. United States fifty (50) states; (10-1-06)T

ii. District of Columbia; (10-1-06)T

iii. Puerto Rico, on or after January 13, 1941; (10-1-06)T

iv. Guam, on or after April 10, 1899; (10-1-06)T

v. U.S. Virgin Islands, on or after January 17, 1917, (10-1-06)T

vi. America Samoa; (10-1-06)T

vii. Swain's Island; or (10-1-06)T

viii. Northern Mariana Islands, after November 4, 1986; (10-1-06)T

b. A certification of report of birth issued by the Department of State, Forms DS-1350

or FS-545; *(10-1-06)T*

c. *A report of birth abroad of a U.S. Citizen, Form FS 240;* *(10-1-06)T*

d. *A U.S. Citizen I.D. card, DHS Form I-197;* *(10-1-06)T*

e. *A Northern Mariana Identification Card, Form I-873;* *(10-1-06)T*

f. *An American Indian Card issued by the Department of Homeland Security with the classification code "KIC," Form I-873;* *(10-1-06)T*

g. *A final adoption decree showing the child's name and U.S. place of birth;* *(10-1-06)T*

h. *Evidence of U.S. Civil Service employment before June 1, 1976; or* *(10-1-06)T*

i. *An official U.S. Military record showing a U.S. place of birth.* *(10-1-06)T*

03. Documents Accepted as Third Level Proof of U.S. Citizenship but Not Identity. *The following documents are accepted as proof of U.S. citizenship if a primary or secondary level of proof is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsection 222.05 or Section 223 of these rules to establish both citizenship and identity.* *(10-1-06)T*

a. *A written hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date that indicates a U.S. place of birth; or* *(10-1-06)T*

b. *Life, health, or other insurance record that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth.* *(10-1-06)T*

04. Documents Accepted as Fourth Level Proof of U.S. Citizenship but Not Identity. *The following documents are accepted as proof of U.S. citizenship only if documents in Subsections 105.01 through 105.03 of these rules do not exist and cannot be obtained for a person who claims U.S. citizenship. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsection 222.05 or Section 223 of these rules to establish both citizenship and identity.* *(10-1-06)T*

a. *Federal or state census record that shows the individual has U.S. citizenship or a U.S. place of birth;* *(10-1-06)T*

b. *One (1) of the following documents that shows a U.S. place of birth and was created at least five (5) years before the application for Medicaid;* *(10-1-06)T*

i. *Seneca Indian tribal census record;* *(10-1-06)T*

ii. *Bureau of Indian Affairs tribal census records of the Navajo Indians;* *(10-1-06)T*

iii. U.S. State vital Statistics official notification of birth registration; (10-1-06)T

iv. An amended U.S. public birth record that is amended more than five (5) years after the person's birth; (10-1-06)T

v. Statement signed by the physician or midwife who was in attendance at the time of birth; (10-1-06)T

vi. Medical (clinic, doctor, or hospital) record; (10-1-06)T

vii. Institutional admission papers from a nursing facility, skilled care facility or other institution; or (10-1-06)T

c. *A written declaration, signed and dated, which states, "I declare under penalty of perjury that the foregoing is true and correct." A declaration is accepted if no other documentation is available and complies with the following: (10-1-06)T*

i. Declarations must be made by two (2) persons who have personal knowledge of the events establishing the individual's claim of U.S. citizenship; (10-1-06)T

ii. One (1) of the persons making a declaration cannot be related to the individual claiming U.S. citizenship; (10-1-06)T

iii. Neither of the two (2) persons making the declaration can be an applicant or recipient of Medicaid; (10-1-06)T

iv. The persons making the declaration must provide proof of their own U.S. citizenship and identity; and (10-1-06)T

v. The persons making the declaration must provide an explanation as to why documentation for the individual does not exist or cannot be obtained. (10-1-06)T

vi. A declaration must be obtained from the individual applying for Medicaid, a guardian, or representative that explains why the documentation does not exist or cannot be obtained. (10-1-06)T

05. Documents Accepted for Proof of Identity but Not Citizenship*. The following documents are accepted as proof of identity. They are not proof of citizenship and must be used in combination with at least one (1) document listed in Subsections 222.01 through 222.04 of this rule to establish both citizenship and identity. (10-1-06)T*

a. *A state-issued driver's license bearing the individual's picture or other identifying information such as name, age, gender, race, height, weight, or eye color; (10-1-06)T*

b. *A federal, state, or local government-issued identity card with the same identifying information that is included on driver's licenses as described in Subsection 222.05.a of this rule; (10-1-06)T*

c. *School identification card with a photograph of the individual;* (10-1-06)T

d. *U.S. Military card or draft record;* (10-1-06)T

e. *Military dependent's identification card;* (10-1-06)T

f. *U. S. Coast Guard Merchant Mariner card;* (10-1-06)T

g. *Certificate of Degree of Indian blood; or* (10-1-06)T

h. *Native American Indian or Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual.* (10-1-06)T

223. IDENTITY RULES FOR CHILDREN.
The following documentation of identity for children under sixteen (16) may be used: (10-1-06)T

01. School Records. *School records may be used to establish identity. Such records also include nursery or day care records.* (10-1-06)T

02. Written Declaration. *A written declaration, signed and dated, which states, "I declare under penalty of perjury that the foregoing is true and correct," if documents listed in Subsection 221.02 of this rule are not available. A declaration cannot be used for identity if a declaration for citizenship documentation was provided for the child. A declaration may be used if it meets the following conditions:* (10-1-06)T

a. *It states the date and place of the child's birth; and* (10-1-06)T

b. *It is signed by a parent or guardian.* (10-1-06)T

224. ELIGIBILITY FOR APPLICANTS AND MEDICAID PARTICIPANTS WHO DO NOT PROVIDE CITIZENSHIP AND IDENTITY DOCUMENTATION.

01. Denial of Eligibility. *Eligibility will be denied to any applicant who does not provide proof of citizenship and identity documentation.* (10-1-06)T

02. Lack of Documentation. *Any Medicaid participant, who does not provide proof of citizenship and identity documentation at a scheduled renewal and who is making a good faith effort to obtain documentation, will not be terminated from Medicaid for lack of documentation unless the participant:* (10-1-06)T

a. *Does not meet other eligibility criteria required in this chapter of rules; or* (10-1-06)T

b. *Refuses to obtain the documentation.* (10-1-06)T

225. INDIVIDUALS CONSIDERED AS MEETING THE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.
SSI recipients and individuals determined by the SSA to be entitled to or are receiving Medicare

are considered to have met the U.S. citizenship and identity documentation requirements, regardless of whether documentation required in Subsections 221.01 through 221.05 or Sections 223 and 224 of these rules are provided: *(10-1-06)T*

226. TITLE IV-E FOSTER CARE CHILD.
The Department will not deny or delay Medicaid for a child receiving Title IV-E Foster Care assistance pending citizenship and identity documentation. *(10-1-06)T*

227. ASSISTANCE IN OBTAINING DOCUMENTATION.
The Department will assist individuals who are mentally or physically incapacitated and who lack a representative to assist them in obtaining such documentation. *(10-1-06)T*

228. PROVIDE DOCUMENTATION OF CITIZENSHIP AND IDENTITY ONE TIME.
When an individual has provided citizenship and identity documents, changes in eligibility will not require an individual to provide such documentation again unless later verification of the documents provided raises a question of the individual's citizenship or identity. *(10-1-06)T*

22~~7~~9. -- 239. (RESERVED).

240. INDIVIDUALS WHO DO NOT MEET THE CITIZENSHIP OR QUALIFIED NON-CITIZEN REQUIREMENTS.
Individuals who do not meet the citizen or qualified non-citizen requirements under Section 220 of these rules may be eligible for emergency medical services if they meet all other conditions of eligibility for a Title XIX or Title XXI program. (7-1-06)T

01. Limited Eligibility. Eligibility for emergency medical assistance under the Title XIX or Title XXI programs is limited to the date(s) of the emergency condition. (7-1-06)T

02. Ineligibility for Premium Assistance. Individuals who do not meet the citizen, qualified non-citizen, or identity requirements in Section 220 of these rules are not eligible for the Premium Assistance program. (7-1-06)T

241. -- 249. (RESERVED).

250. EMERGENCY MEDICAL CONDITION.
Individuals who do not meet citizenship requirements may receive medical assistance under any Title XIX or Title XXI coverage group, except Premium Assistance, for medical services necessary to treat an emergency medical condition, including labor and delivery. Emergency medical conditions have acute symptoms of severity, including severe pain. The Department determines if a condition meets criteria of an emergency condition. Medical assistance is limited to the period of time established for the emergency condition. For undocumented individuals with emergency conditions, the Social Security Number (SSN) requirement is waived because an SSN cannot be issued. Individuals must be otherwise eligible for Title XIX. (7-1-06)T

251. SPONSOR DEEMING.
Income and resources of a legal non-citizen's sponsor and the sponsor's spouse are counted in determining eligibility. (7-1-06)T

252. SPONSOR RESPONSIBILITY.
Section 213 of the Immigration and Naturalization Act requires that a sponsor signing Form I-864, Affidavit of Support, reimburse the Department for Health Care Assistance benefits paid for a sponsored, qualified non-citizen. (7-1-06)T

253. -- 269. (RESERVED).

270. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.
An applicant must provide his Social Security Number (SSN), or proof he has applied for an 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. When an SSN is unverified, the applicant is not eligible for Health Care Assistance. The Department must notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. (7-1-06)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. (7-1-06)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: (7-1-06)T

a. Is a member of a recognized religious sect or division of the sect; and (7-1-06)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. (7-1-06)T

03. SSN Requirement Waived. An applicant may have the SSN requirement waived when he is: (7-1-06)T

a. Only eligible for emergency medical services as described in Section 250 of these rules; or (7-1-06)T

b. A waived newborn child as described in Section 530 of these rules. (7-1-06)T

271. -- 279. (RESERVED).

280. GROUP HEALTH PLAN ENROLLMENT.
Title XIX and Title XXI participants must apply for and enroll in a cost-effective group health plan if one is available. A cost-effective health plan is one which has premiums and co-payments at a lower cost than Medicaid would pay for full medical services. Medicaid will pay premiums and other co-payments for plans the Department finds cost-effective. (7-1-06)T

281. -- 289. (RESERVED).

290. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY LIABILITY.
By operation of Section 56-203B and Section 56-209b(3), Idaho Code, medical support rights are assigned to the Department by signature on the application for assistance. The participant must cooperate to secure medical support from any liable third party. The cooperation requirement may be waived if the participant has good cause for not cooperating. (7-1-06)T

291. MEDICAL SUPPORT COOPERATION.
A Medicaid recipient responsible for assigning their rights to medical support must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify and enforce a medical support order. (7-1-06)T

01. Cooperation Defined. Cooperation includes providing all information to identify and locate the non-custodial parent and identifying other liable third party payers. The participant must provide the first and last name of the non-custodial parent. The participant must also provide at least two (2) of the following pieces of information about the non-custodial parent: (7-1-06)T

a. Birth date; (7-1-06)T

b. Social Security Number; (7-1-06)T

c. Current address; (7-1-06)T

d. Current phone number; (7-1-06)T

e. Current employer. (7-1-06)T

f. Make, model, and license number of any motor vehicle owned by the non-custodial parent; or (7-1-06)T

g. Names, phone numbers and addresses of the parents of the non-custodial parent. (7-1-06)T

02. Good Cause Defined. The participant may claim good cause for failure to cooperate in securing medical support for a minor child. Good cause is limited to the following reasons: (7-1-06)T

a. There is proof the child was conceived as a result of incest or rape; (7-1-06)T

b. There is proof the child's non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent or the caretaker relative; or (7-1-06)T

c. A credible explanation is provided showing the participant cannot provide the minimum information regarding the non-custodial parent. (7-1-06)T

d. A participant who has good cause for not cooperating as described in Subsection 291.03.b of this rule. (7-1-06)T

03. Conditions for Non-Denial of Medicaid. Medicaid cannot be denied for individuals who meet one (1) of the following conditions: (7-1-06)T

a. A child or unmarried minor child who cannot legally assign his rights to medical support; or (7-1-06)T

b. A pregnant woman whose income is at or below the federal poverty guideline, and who does not cooperate in establishing paternity and obtaining medical support from, or derived from, the father of the unborn child. (7-1-06)T

292. COOPERATION WITH HEALTHY CONNECTIONS PROGRAM.
Applicants must cooperate with Healthy Connections in establishing a Primary Care Provider unless exempt under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." If a primary care provider is not chosen by the applicant, Healthy Connections will choose the primary care provider for the participant. (7-1-06)T

293. COST-SHARING REQUIREMENT.
Participants are required to pay a cost-sharing premium based on the level of their family income as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." Individuals who fail to pay their cost-sharing premium and become delinquent cannot receive Heath Care Assistance. (10-1-06)T

294. -- 295. (RESERVED).

296. COOPERATION WITH THE QUALITY CONTROL PROCESS.
When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. (7-1-06)T

297. -- 299. (RESERVED).

FINANCIAL REQUIREMENTS
(Sections 300 Through 314)

300. FINANCIAL RESPONSIBILITY.
The income and resources of individuals who are financially responsible for the participant are counted in determining eligibility. Individuals are financially responsible for themselves. Parents are financially responsible for their adoptive and biological children but not step children. Spouses are financially responsible for each other. (7-1-06)T

301. FINANCIAL ELIGIBILITY.
To be eligible for Health Care Assistance, a participant must meet the income and resource limits. (7-1-06)T

302. -- 314. (RESERVED).

RESOURCES

(Sections 315 Through 344)

315. RESOURCE DEFINITION.
Resources are liquid assets, vehicles, and real property with a cash value upon disposition. Resources are available when the participant has the legal right to dispose of the resource and can do so in a reasonable length of time. (7-1-06)T

316. DETERMINING RESOURCE ELIGIBILITY FOR AFDC-RELATED ADULTS AND LOW INCOME PREGNANT WOMEN.
Resources are considered in determining eligibility for AFDC-related adult Medicaid and Low Income Pregnant Women. The following information is required to determine a participant's resource eligibility: (7-1-06)T

01. Countable Resources. The equity value of all countable non-excluded resources is compared to the resource limit for AFDC Medicaid adults and Low Income Pregnant Women. (7-1-06)T

02. Initial Eligibility. For initial eligibility, the value of countable resources is determined as of the application date. (7-1-06)T

03. Excess Countable Resources. Excess countable resources anticipated at any time during an upcoming month, affects the entire month's eligibility. (7-1-06)T

317. -- 324. (RESERVED).

325. RESOURCE LIMITS.
The resource limit for AFDC-related coverage groups is one thousand dollars ($1,000). The resource limit for the Low Income Pregnant Woman coverage group is five thousand dollars ($5,000). (7-1-06)T

326. EQUITY VALUE OF RESOURCES.
Resources are counted according to their equity value. This is the value of the resource after all liens, mortgages and other encumbrances against the resource are subtracted. (7-1-06)T

327. VEHICLES.
For both AFDC-related and Low Income Pregnant Woman related Medicaid, one (1) vehicle, regardless of value, is excluded. In two (2) parent families, a second vehicle used for medical transportation, or seeking or retaining employment, is also excluded. The equity value of each additional vehicle, licensed or unlicensed, is a resource. The value of special equipment for the use or transportation of a disabled person is not counted when determining the equity value. (7-1-06)T

328. BANK ACCOUNTS.
Money deposited to a bank account by the participant is a countable resource. Income not spent in the month received is counted as a resource the next month. (7-1-06)T

329. -- 339. (RESERVED).

340. SALES CONTRACTS.
A mortgage, promissory note, or other form of sales contract, that can be sold is a resource. (7-1-06)T

341. PROPERTY TRANSFER.
When determining Medicaid eligibility for any family medical coverage group, there is no asset transfer penalty. (7-1-06)T

342. RESOURCES EXCLUDED BY FEDERAL LAW.
A resource excluded by federal law is not counted in determining the resource amount available to the participant. (7-1-06)T

343. -- 344. (RESERVED).

INCOME
(Sections 345 Through 394)

345. AVAILABLE INCOME.
Income is available when the participant has a legal interest in a liquidated sum. 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. (7-1-06)T

346. DETERMINING INCOME ELIGIBILITY.
Income from financially-responsible household members is counted to determine an individual's eligibility. The individual's countable income must be calculated using actual income already received and anticipated income that can reasonably be expected during the month the application is submitted. Eligibility for Health Care Assistance is determined by comparing the individual's calculated income against the income limit. (7-1-06)T

347. EARNED INCOME.
Earned income is derived from labor or active participation in a business. The income can be wages, tips, salary, commissions, advances, jury duty payments, sale of plasma, vacation pay, bonuses, living allowance or stipend from AmeriCorps and Senior Corps, or profit from employment or self-employment. Earned income is gross earnings before deductions for taxes or any other purposes. It is counted as income when it is received, or would have been received except for the decision of the participant to postpone receipt. Earnings over a period of time and paid at one (1) time, such as the sale of farm crops, livestock, or poultry, are annualized and self-employment expenses deducted. (7-1-06)T

348. CHILD'S EARNED INCOME.
A child's earned income is excluded. (7-1-06)T

349. INCOME PAID UNDER CONTRACT.
The earned income of an employee paid on a contractual basis is prorated over the period of the contract. (7-1-06)T

350. IN-KIND INCOME.
An individual who receives a service, benefit, or durable goods instead of wages is earning in-kind income. In-kind income is excluded. (7-1-06)T

351. SELF-EMPLOYMENT EARNED INCOME.
Income from self-employment is treated as earned income. Countable self-employment income is the difference between the gross receipts and the allowable costs of producing the self-employment income, if the amount is expected to continue. (7-1-06)T

01. Allowable Costs of Producing the Self-Employment Income. Allowable costs of producing the self-employment income include: (7-1-06)T

a. The cost of labor paid to persons not in the home; (7-1-06)T

b. The cost of stock; (7-1-06)T

c. The cost of material; (7-1-06)T

d. The cost for rent and utilities, advertising, shipping and legal fees; (7-1-06)T

e. The cost of seed and fertilizer; (7-1-06)T

f. Interest paid to purchase income-producing property, including real estate; (7-1-06)T

g. Insurance premiums; (7-1-06)T

h. Taxes paid on income-producing property; (7-1-06)T

i. Transportation, when a vehicle is an integral part of business activity; and (7-1-06)T

j. Expenses directly related to producing the goods or services and, without which, the goods or services could not be produced. (7-1-06)T

02. Non-Allowable Costs of Producing the Self-Employment Income. The non-allowable costs of producing the self-employment income are: (7-1-06)T

a. Payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable goods; (7-1-06)T

b. Net losses from previous periods; (7-1-06)T

c. Federal, State, and local income taxes; (7-1-06)T

d. Money set aside for retirement; (7-1-06)T

e. Personal expenses such as meals and transportation to and from work; (7-1-06)T

f. Personal business, personal entertainment expenses, and personal transportation costs which are not an integral part of business activity; and (7-1-06)T

g. Depreciation. (7-1-06)T

352. OFFSETTING FARM SELF-EMPLOYMENT LOSSES.
If a farmer's cost of producing self-employment income results in a loss, the loss must be subtracted from other countable income in the household. The losses from non-farm self-employment income must be subtracted first. If any loss remains, the remaining loss must be subtracted from the total of earned income. If any loss still remains, the remaining loss must be subtracted from the total of unearned income. Net losses from the self-employment income of a farmer are prorated over the calendar year and do not carry over from year to year. (7-1-06)T

353. -- 369. (RESERVED).

370. UNEARNED INCOME.
Unearned income is any income the individual receives that is not gained through employment. Unearned income includes payments from pensions, Retirement, Survivors, and Disability Insurance (RSDI), unemployment compensation, worker's compensation, veteran's benefits, other government benefits, Temporary Assistance for Families in Idaho (TAFI), Temporary Assistance to Needy Families (TANF), contributions, support payments, cash gifts and capital investment returns, such as dividends and interest. (7-1-06)T

371. SUPPORT INCOME.
Support income is any payment a non-custodial parent or absent spouse makes to the individual. The payment is support when either parent defines it as such, or when the payment is used to meet the individual's needs. A child support payment is unearned income to the child. A spousal support payment is unearned income to the individual who receives it. (7-1-06)T

372. RENTAL INCOME FROM REAL PROPERTY.
Rental income is payment for the use of real or personal property. Rental payments may be received for the use of land, buildings, apartments, houses, or for machinery and equipment. The net rental income is the gross rental receipts less ordinary and necessary expenses of producing the income. The net rental income is unearned income when all activities associated with the rental are performed by an outside agency. If an outside agency is not performing activities, the net rental income is self-employment income. (7-1-06)T

373. UNEARNED INCOME COVERING MORE THAN ONE MONTH.
Unearned income received less often than monthly; such as quarterly, semi-annually, or annually, is prorated over the period of the time it is intended to cover. (7-1-06)T

374. INTEREST AND DIVIDEND INCOME.
Interest posted to any financial institution account on a monthly, quarterly, or any other regular basis is unearned income in the month received. Dividends are unearned income in the month received. (7-1-06)T

375. RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI) INCOME.
The amount of the entitlement to Retirement, Survivors, and Disability Insurance (RSDI) benefits is counted as unearned income, unless an overpayment is being withheld. If an overpayment is being withheld, the net amount of the RSDI is unearned income. (7-1-06)T

376. MONEY GIFTS.
Money gifts received for occasions such as birthdays, Christmas, graduation, anniversaries, or cash rewards, is unearned income when the amount exceeds thirty dollars ($30) per person in a calendar quarter. (7-1-06)T

377. CONTRIBUTIONS.
Contributions are cash payments from persons who are not legally liable to support the individual or family. Contributions are unearned income. The contributions are counted prospectively, if they can reasonably be anticipated. (7-1-06)T

378. DISABILITY INSURANCE PAYMENTS.
Disability payments paid to an individual through an insurance company are unearned income in the month received. (7-1-06)T

379. INCOME FROM ROOMER OR BOARDER.
Income from a commercial boarding house is earned income. Income from other room and board situations is unearned income. (7-1-06)T

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. (7-1-06)T

381. INCOME FROM SALE OF REAL PROPERTY.
Monthly payments, minus prorated taxes and insurance costs, received by a participant for the sale of real property are unearned income. (7-1-06)T

382. EDUCATIONAL INCOME.
Any student financial assistance provided under Title IV of the Higher Education Act, the Bureau of Indian Affairs education program, grants, loans, scholarships, or work study is excluded. (7-1-06)T

383. MEDICAL INSURANCE PAYMENTS.
Monthly insurance payments are unearned income if not used for the intended purpose of paying medical expenses or if the obligation to pay the medical expenses no longer exists because they are being paid by another source. (7-1-06)T

384. LUMP SUM INCOME.
A non-recurring lump sum payment is income in the month received. Lump sum income is a retroactive monthly benefit or a windfall payment. This may be earned or unearned income, paid in a single sum. Lump sum income includes Retirement, Survivors, and Disability Insurance (RSDI), Veteran's Administration (VA), worker compensation awards, severance pay, disability

insurance, and lottery winnings. (7-1-06)T

01. Lump Sum Received in Initial Month of Eligibility. Lump sum income received in the application month is counted as income for that month. (7-1-06)T

02. Lump Sum Received in Any Other Month of Eligibility. If the lump sum income can be anticipated, the lump sum is counted as income in the month income is expected. Any portion of the lump sum left after the month of receipt is a countable resource. (7-1-06)T

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: (7-1-06)T

01. Agent Orange Settlement Funds. Payments made to veterans from the Agent Orange Settlement Fund. (7-1-06)T

02. Alaska Native Claims. Tax-exempt portions of payments made in accordance with the Alaska Native Claims Settlement Act, PL 92-203. (7-1-06)T

03. AmeriCorps. AmeriCorps payments for child care allowances and educational awards, other than stipends or living allowances, are excluded. (7-1-06)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. (7-1-06)T

05. Commodities and Food Stamps. The value of U.S. Department of Agriculture donated commodities and Food Stamps. (7-1-06)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. (7-1-06)T

07. Elderly Nutritional Benefits. Any benefits received under Title VII, Nutritional Program for the Elderly, of the Older Americans Act of 1965. (7-1-06)T

08. Foster Care and Adoption Assistance Payment. Foster care payments paid by the Department are excluded. Adoption Assistance payments paid by federal, state or local agencies are excluded. (7-1-06)T

09. Garnishments. Income garnished by court order is not available and is excluded. (7-1-06)T

10. Home Energy Assistance. PL 100-203 excludes Home Energy Assistance. The aid must be provided based on need certified by the Department. (7-1-06)T

11. Home Produce. The value of home produce used by the family. (7-1-06)T

12. Housing Subsidies. The value of government rent or housing subsidies or both, if the participant receives both. (7-1-06)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. (7-1-06)T

14. Income Tax Refunds and Earned Income Tax Credit (EITC) Payments. Income tax refunds are excluded from income, but counted as a resource. Earned Income Tax Credit payments, or the advance payment of the EITC, is excluded. (7-1-06)T

15. Indian Payments. Payments distributed to or held in trust for members of any Indian tribe issued under 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. (7-1-06)T

16. Loans. A bona fide loan is not available income. (7-1-06)T

17. Low Income Energy Assistance. Money paid to families under the Low Income Energy Assistance Act of 1981 under 42 U.S.C. 8624(f) is excluded. (7-1-06)T

18. Radiation Exposure Compensation Act. Payments made to individuals under this act are excluded. (7-1-06)T

19. Relocation Assistance. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, contained in 42 U.S.C. Subsection 4636 of the U.S. Code, and relocation payments paid to civilians of World War II per Public Law 100-383. (7-1-06)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. (7-1-06)T

21. Senior Volunteer Programs. Payments for supportive services or out-of-pocket expenses made to individual volunteers serving as foster grandparents, Vista volunteers, 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, and 93-143. This Federal Code is contained in Titles 5 and 42 of the U.S. Code. (7-1-06)T

22. Spina Bifida. Spina bifida allowances paid to children of Vietnam veterans. (7-1-06)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. (7-1-06)T

24. Utility Reimbursement Payments. Utility reimbursement payments made to persons living in housing subsidized by HUD. (7-1-06)T

25. Work-Related Payments. Payments made by an employer for work-related expenses are excluded. Work-related expenses include travel and per diem. (7-1-06)T

386. COUNTING TEMPORARY ASSISTANCE TO FAMILIES IN IDAHO (TAFI) INCOME.
Individuals and families are eligible for health care assistance if: (7-1-06)T

01. TAFI and Idaho Tribal Temporary Assistance for Needy Families Income. Their only income is Idaho TAFI or Idaho Tribal TANF. (7-1-06)T

02. TAFI, Idaho Tribal TANF, and Other Unearned Income. Their only income is a combination of Idaho TAFI, Idaho Tribal TANF, and other unearned income, but whose total income is equal to, or less than, the current Idaho TAFI maximum grant amount. (7-1-06)T

03. TAFI or Idaho Tribal TANF Income and Medicaid-Eligible. Their income includes Idaho TAFI or Idaho Tribal TANF, and they meet the Medicaid financial eligibility criteria described in Sections 345 through 388 of these rules. (7-1-06)T

387. COUNTING OUT-OF-STATE TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BENEFITS.
When determining eligibility for Title XIX or Title XXI health coverage, TANF payments received from other states are countable unearned income. (7-1-06)T

388. CHILD'S UNEARNED INCOME.
A child's unearned income is countable towards his eligibility. (7-1-06)T

389. -- 394. (RESERVED).

DISREGARDS
(Section 395 Through 399)

395. EARNED INCOME DISREGARDS FOR AFDC-RELATED ADULTS AND LOW INCOME PREGNANT WOMEN.
Earned income disregards are subtracted from earnings after they are converted to a monthly amount, if the participant is not eligible without the disregards. The earned income disregards are subtracted from earnings in the following order: (7-1-06)T

01. The Standard Disregard. The first ninety dollars ($90) of an individual's earned income is disregarded. (7-1-06)T

02. Thirty Dollars Plus One-Third Disregard. Thirty dollars ($30) plus one-third (1/3) is disregarded when the earned income belongs to a single parent, a relative caretaker receiving Title XIX benefits, a pregnant woman, or a parent in a two (2) parent family receiving Title XIX benefits because of unemployment or incapacity. The disregard is allowed only if earned income, minus ninety ($90) and allowable child care, is below the AFDC need standard for the budget unit. The disregard is not allowed after four (4) consecutive months. (7-1-06)T

03. Thirty Dollars Only Disregard. Thirty dollars ($30) are disregarded for eight (8) months following the expiration of the thirty dollars ($30) plus one-third (1/3) disregard. (7-1-06)T

04. The 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 adult living in the same home. The amount disregarded is the anticipated cost of care paid by the participant or the maximum care allowance, whichever is less. Maximum dependent care allowances are listed in Subsections 395.05 and 395.06 of this rule. Dependent care costs paid by a third party are not an allowable disregard. (7-1-06)T

05. Dependents Two Years of Age or Older. Dependents, two (2) years of age or older, 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. (7-1-06)T

06. 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. (7-1-06)T

396. -- 399. (RESERVED).

HEALTH COVERAGE FOR ADULTS
(Sections 400 Through 499)

400. AFDC-RELATED BUDGET UNIT.
A budget unit is a person or group of persons who are relatives of specified degree who live in the same home with an eligible dependent child. Their needs, income, and resources are counted as a unit for AFDC adult eligibility. Eligibility is based on the number of budget unit members. (7-1-06)T

01. Member of More Than One Budget Unit. No person may receive benefits in more than one (1) budget unit during the same month. (7-1-06)T

02. More Than One Medicaid Budget Unit in Home. If there is more than one (1)

Medicaid budget unit in a home, each budget unit is considered a separate unit. (7-1-06)T

03. Budget Units Not Separate. Budget units cannot be separate if any member is a required member of both units. The units must be combined and treated as one (1) unit. (7-1-06)T

401. PERSONS WHO MUST BE INCLUDED IN AN AFDC-RELATED BUDGET UNIT.
Persons listed in Subsections 401.01 through 401.05 of this rule must be included in an AFDC-related budget unit. (7-1-06)T

01. Parents. A biological or adoptive parent must be included in the budget unit. Both parents must be included if: (7-1-06)T

a. One (1) or both parents is incapacitated; (7-1-06)T

b. One (1) parent is receiving AABD Title XIX based on the Community Property method and is not an SSI recipient; or (7-1-06)T

c. One (1) is unemployed or underemployed, or both parents are unemployed or underemployed. (7-1-06)T

02. Disqualified Parents. Disqualified parents needs are not included when determining the size of the budget unit. A disqualified parent's income and resources are counted in full. A parent is disqualified if: (7-1-06)T

a. He does not meet the non-financial eligibility criteria found in Sections 200 through 240 of these rules; or (7-1-06)T

b. He fails to cooperate with Medicaid requirements found in Sections 270 through 296 of these rules. (7-1-06)T

03. Siblings. A child's biological or adoptive brother or sister, including half-siblings, must be included in the budget unit. (7-1-06)T

04. Pregnant Woman With No Other Children. A pregnant woman, who does not have a child residing in the home, may receive AFDC-related benefits. (7-1-06)T

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 AFDC-related eligibility. (7-1-06)T

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 AFDC-related benefits until the child is born and paternity is established. (7-1-06)T

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.

(7-1-06)T

402. PERSONS WHO MAY BE INCLUDED IN AN AFDC-RELATED BUDGET UNIT.
Persons listed in Subsections 402.01 through 402.03 of this rule may be included in an AFDC-related budget unit. They may choose not to be included. (7-1-06)T

01. Other Child in Home. A child who is a relative of specified degree but is not a biological or adoptive child of a budget unit member and not a sibling or half-sibling of other children in the budget unit, can be included. (7-1-06)T

02. Child of Pregnant Woman. A pregnant woman's children can be included. If any children are included, all siblings must be included. (7-1-06)T

03. Caretaker Relative Other Than Parent. In the absence of both, biological or adoptive parents, one (1) caretaker relative of specified degree can be included. (7-1-06)T

403. PERSONS WHO MUST NOT BE INCLUDED IN AN AFDC-RELATED BUDGET UNIT.
Persons listed in Subsections 403.01 through 403.06 of this rule must not be included in an AFDC-related budget unit. (7-1-06)T

01. SSI Recipient. Persons who receive SSI benefits must not be included. (7-1-06)T

02. AABD State Supplemented Recipient. Persons who receive AABD cash benefits must not be included. (7-1-06)T

03. Stepparent Without Common Child. Stepparents must not be included, unless there is a common child and the child's parent is incapacitated or unemployed. (7-1-06)T

04. Ineligible Non-Citizen. Persons who are ineligible non-citizens must not be included. (7-1-06)T

05. Title IV-E Foster Child. A child who receives foster care payments from the Department must not be included. (7-1-06)T

06. Adoption Assistance. A child who receives adoption assistance payments from any federal, state, or local agency providing adoption assistance payments must not be included. (7-1-06)T

404. -- 409. (RESERVED).

410. DETERMINING MEDICAID ELIGIBILITY FOR AFDC-RELATED ADULTS.
Countable monthly income and resources for each individual are compared to the income and resource payment standard. When income or resources exceed standards, the individual is ineligible. (7-1-06)T

411. AFDC-RELATED COVERAGE GROUPS INCOME LIMITS.
The AFDC income limits are based on the number of budget unit members. The income limits are

listed in Table 411.

TABLE 411 AFDC INCOME LIMITS		
Number In Family	Payment Income Limit	Need Income Limit
1	$205	$643
2	$251	$786
3	$317	$991
4	$382	$1,196
5	$448	$1,401
6	$513	$1,606
7	$579	$1,811
8	$645	$2,016
9	$710	$2,221
10	$776	$2,426
Over 10 Persons	Add $65 Each	Add $205 Each

(7-1-06)T

412. -- 419. (RESERVED).

420. EXTENDED MEDICAID FOR SPOUSAL *OR CHILD* SUPPORT INCREASE.
Participants are eligible for four (4) calendar months of Extended Medicaid if an increase in the participant's spousal *or child* support causes them to exceed the income limit for their budget unit size. The participant must have received AFDC-related Medicaid in Idaho in at least three (3) of the six (6) months before the month the participant became income ineligible. ~~*(7-1-06)T*~~(7-1-06)T

421. TRANSITIONAL MEDICAID.
Participants are eligible for twelve (12) continuous months of Transitional Medicaid if the family income exceeds limits because of a reason listed in Subsections 421.01 through 421.02 of this rule. The participants must have received AFDC-related Medicaid in Idaho in three (3) of the six (6) months before the month they became ineligible unless the family income exceeds limits because they have Idaho TAFI income and income from employment. (7-1-06)T

01. Employment Income Increased. Family income exceeds limits because employment income increased. (7-1-06)T

02. Disregard Expired. Family income exceeds limits because the thirty dollar ($30) plus one-third (1/3) or the thirty dollar ($30) disregard expired. (7-1-06)T

422. REASONS TO END TRANSITIONAL MEDICAID BEFORE THE END OF THE ELIGIBILITY PERIOD.
Reasons to end Transitional Medicaid are: (7-1-06)T

01. Child Leaves Family Unit. The family unit no longer includes an eligible child. (7-1-06)T

02. Not Residing in Idaho. The family unit no longer resides in Idaho. (7-1-06)T

03. Failure to Cooperate. The caretaker relative fails to cooperate in obtaining medical support and third party payments. In this case, the caretaker relative is ineligible. (7-1-06)T

04. Member Committed Fraudulent Acts. It is determined a member of the family unit committed fraud during the last six (6) months the family received Medicaid, before getting Transitional Medicaid. The remaining members of the family unit remain eligible. (7-1-06)T

423. TRANSITIONAL MEDICAID FAMILY RETURNS TO IDAHO.
If Transitional Medicaid is closed because the family left the state, the Transitional Medicaid is reopened if the family returns to Idaho during the twelve (12) month period. The participants remain eligible for the rest of the original twelve (12) months if all eligibility requirements are met. The months of absence are counted as if the participants had actually received Transitional Medicaid during those months. (7-1-06)T

424. NEW PERSONS MOVE INTO TRANSITIONAL MEDICAID HOME.
New persons moving into the home during the twelve (12) month Transitional Medicaid period are eligible for Medicaid if they are mandatory members of the budget unit as described in Section 401 of these rules. (7-1-06)T

425. -- 499. (RESERVED).

PREGNANCY-RELATED HEALTH COVERAGE
(Sections 500 Through 519)

500. LOW INCOME PREGNANT WOMAN.
A pregnant woman of any age is eligible for the Low Income Pregnant Woman coverage group if she meets all of the non-financial and financial criteria of the coverage group. Health care assistance for a participant in the Low Income Pregnant Woman coverage group is limited to pregnancy-related and postpartum services. The Low Income Pregnant Woman medical assistance coverage extends through the sixty (60) day postpartum period if she applied for medical assistance while pregnant and was receiving medical assistance when the child was born. An individual who applies for Low Income Pregnant Woman medical assistance after the child is born is not eligible for the sixty-day (60) postpartum period. (7-1-06)T

01. Income Limit. The individual's countable income which is calculated using allowable income disregards must not exceed one hundred thirty-three percent (133%) of the FPG for her family size in the application month. (7-1-06)T

02. Family Size. Family members include the pregnant woman and the unborn child.

Family members also include the spouse, minor dependent children, and minor step-children, if living with the pregnant woman. Other related or non-related children may be included if they live with the pregnant woman. Family members are counted regardless of Medicaid ineligibility or disqualification. Family members who receive SSI or AABD payments are not included. For an individual Medicaid determination, only income and resources of persons financially responsible for the individual can make the individual ineligible for Medicaid. (7-1-06)T

03. Income Disregards. Allowable income exclusions and disregards, described in Section 395 of these rules, are subtracted to determine the pregnant woman's income. (7-1-06)T

04. Continuing Eligibility. The pregnant woman remains eligible during the pregnancy regardless of changes in income. Changes in resources and non-financial criteria must be considered prospectively. The woman must report the end of pregnancy to the Department within ten (10) days. (7-1-06)T

05. Resource Limit for Adult Pregnant Women. The resource limit is described in Section 325 of these rules. (7-1-06)T

501. PREGNANT WOMAN INELIGIBLE BECAUSE OF EXCESS INCOME.
A pregnant woman who receives health care assistance and becomes ineligible because of an increase in income will continue to receive coverage as a Low Income Pregnant Woman. (7-1-06)T

502. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN.
A pregnant woman can get limited ambulatory prenatal care as a presumptively eligible (PE) pregnant woman through the end of the month after the month the provider completes the PE determination. PE coverage is designed to provide some prenatal care during the time between the pregnancy diagnosis and the eligibility determination. A qualified PE provider accepts written requests for these services and completes the eligibility determination. The qualified PE provider must inform the participant how to complete the formal application process. Qualified PE providers are required to send the result of the PE decision and the completed application for the Low Income Pregnant Woman to the Department within two (2) working days of the PE determination. Notice and hearing rights of the Title XIX Medicaid program do not apply to the PE decisions. An individual is eligible for only one (1) period of PE coverage during each pregnancy. (7-1-06)T

503. -- 519. (RESERVED).

HEALTH COVERAGE FOR CHILDREN
(Sections 520 Through 529)

520. FINANCIAL ELIGIBILITY.
Children are eligible for Health Care Assistance when the family's total income is less than or equal to one hundred eighty-five percent (185%) of Federal Poverty Guideline for the family size. Neither earned nor unearned income disregards are allowed in determining a child's eligibility for Title XIX or Title XXI. There is no resource test or limit for children. (7-1-06)T

521. FINANCIAL RESPONSIBILITY.
The income of individuals who are financially responsible for the child is counted in determining eligibility. Individuals are financially responsible for themselves. Parents are financially responsible for their adoptive and biological children but not step children. Spouses are financially responsible for each other. (7-1-06)T

522. FAMILY SIZE.
Family members living with the child are counted in the family size. Family members include the child, parent(s), stepparent, minor siblings, minor half-siblings, minor step-siblings, and the child's children. Otherwise related and non-related minor children are optional members. Family members are counted in the family size regardless of Medicaid ineligibility or disqualification. Persons receiving SSI or AABD payments are not included in family size. (7-1-06)T

523. ~~*CHILD WHO IS ENROLLED IN A CREDITABLE HEALTH INSURANCE OR IS A DEPENDANT OF A STATE EMPLOYEE IS NOT ELIGIBLE*~~ *ACCESS TO OR COVERAGE UNDER OTHER HEALTH PLANS*.
~~*A child who is enrolled in a creditable health insurance plan or is a dependent of a state employee is not eligible for direct coverage if he meets one (1) of the following conditions*~~ *A child is ineligible for coverage under the SCHIP plan if they have access to or are enrolled in other health coverage plans as described below*: ~~*(7-1-06)T*~~(7-1-06)T

01. ~~***Child Under Age Six***. *Child under age six (6) and the countable household income exceeds one hundred and thirty-three percent (133%) of the FPG for his family size and is less than or equal to one hundred eighty five percent (185%) of the FPG for his family size; or*~~ ***Idaho State Employee Benefit Plan***. *The child is eligible to receive health insurance benefits under Idaho's State employee benefit plan, or* ~~*(7-1-06)T*~~(7-1-06)T

02. ~~***Child Age Six Through the Month of His Nineteenth Birthday***. *Child age six (6) through the month of his nineteenth birthday and the countable family income exceeds one hundred percent (100%) of the FPG for his family size and is less than or equal to one hundred eighty five (185%) of the FPG for his family size.*~~ ***Covered by Creditable Health Insurance***. *The child is covered by creditable health insurance at the time of application, or*
~~*(7-1-06)T*~~(7-1-06)T

03. ***Dropped from Creditable Coverage***. *The child has been voluntarily dropped from creditable coverage in the six (6) months preceding application with the intention of qualifying for public coverage, or* *(7-1-06)T*

04. ***Eligible for Title XIX***. *The child is eligible under Idaho's Title XIX State Plan.*
(7-1-06)T

524. CHILD DISENROLLED TO QUALIFY FOR DIRECT COVERAGE.
If a child is disenrolled from creditable insurance in the six (6) months prior to his application with the intent to qualify for direct coverage, he is not eligible for direct coverage. A child who is disenrolled from creditable health coverage through no fault of his own will not be denied direct coverage under this provision. A child did not disenroll with the intent to qualify if he lost creditable insurance for one of the following reasons: (7-1-06)T

01. Loss of Employment. The child lost health insurance due to the loss of his parent's employment, or (7-1-06)T

02. Employer Sponsored Insurance.The employee lost eligibility for his employer sponsored insurance, or (7-1-06)T

03. Creditable Insurance Coverage.The employer stopped providing creditable insurance coverage, or (7-1-06)T

04. Parent's Coverage. The child lost access to his health insurance because his parent can no longer legally cover him with employer-sponsored insurance. (7-1-06)T

525. CONTINUOUS HEALTH CARE ASSISTANCE ELIGIBILITY FOR CHILDREN UNDER AGE NINETEEN.
Children under age nineteen (19), who are found eligible in an initial determination or a renewal, remain eligible for a period of twelve (12) months. The twelve (12) month continuous eligibility period does not apply if, for any reason, eligibility was determined incorrectly. (7-1-06)T

01. Reasons Continuous Eligibility Ends. Continuous eligibility for children stops for one (1) of the following reasons: (7-1-06)T

a. The child is no longer an Idaho resident; or (7-1-06)T

b. The child dies; or (7-1-06)T

c. The participant requests closure; or (7-1-06)T

d. The child turns nineteen (19) years of age as defined in Subsection 010.05 of these rules. (7-1-06)T

02. Children Not Eligible for Continuous Eligibility. Children are not eligible for continuous eligibility for one (1) of the following reasons: (7-1-06)T

a. A child is approved for emergency medical services; or (7-1-06)T

b. A child is approved for pregnancy-related services. (7-1-06)T

527. -- 529. (RESERVED).

SPECIAL CIRCUMSTANCES FOR CHILDREN
(Sections 530 Through 549)

530. NEWBORN CHILD.
A newborn child is eligible for health care assistance for one (1) year under the conditions listed

in Subsections 530.01 and 530.02 of this rule. Other non-financial criteria are not applied until a renewal is made. (7-1-06)T

01. Mother Under Title XIX. If the newborn's mother is receiving services under Title XIX at the time of the child's birth; or (7-1-06)T

02. Mother Under Title XXI and Is at 133% to 150% of FPG. If the newborn's mother is receiving services under Title XXI, and is at one hundred thirty-three (133%) to one hundred fifty percent (150%) of the FPG at the time of the child's birth. (7-1-06)T

531. MINOR PARENT LIVING WITH PARENTS.
A minor parent is a child under the age of eighteen (18) who is pregnant or has a child. Minor parents who live with their parents may be eligible for Health Care Assistance for themselves and their children. The minor parents parent(s) are not required to apply. The minor parents parent(s) income is deemed to the minor parent. The minor parent must meet financial and non-financial criteria. (7-1-06)T

532. RESIDENT OF AN ELIGIBLE INSTITUTION.
A resident of an eligible institution must meet all non-financial and financial criteria of Title XIX or Title XXI. Eligible institutions are medical institutions, intermediate care facilities, child care institutions for foster care, or publicly-operated community residences serving no more than sixteen (16) residents. (7-1-06)T

533. CHILDREN WITH SPECIAL CIRCUMSTANCES AND MEDICAID.
Children who receive foster care or are in adoptive placements are eligible for Medicaid. The children must meet non-financial criteria and must meet the financial requirements described for the children's coverage group. (7-1-06)T

534. ADOLESCENT RESIDENT OF IDAHO STATE HOSPITAL SOUTH.
A child residing in Idaho State Hospital South may be eligible for Health Care Assistance if the following conditions are met. (7-1-06)T

01. Under Age Twenty-One. The child is under age twenty-one (21). (7-1-06)T

02. Income. The child's income is less than two hundred and thirteen dollars ($213) per month. Income exclusions and disregards apply to the child's income and an additional seventy dollars ($70) is deducted. (7-1-06)T

535. TITLE IV-E FOSTER CARE CHILD.
A child may be eligible for Health Care Assistance as a Title IV-E foster care child if the following conditions are met. (7-1-06)T

01. Financial. A child meets the financial condition of AFDC-related Medicaid, or would have received Medicaid in the coverage group if someone had applied. The financial condition must be met in the month a court action was initiated to remove the child from his home or the month a voluntary placement agreement is signed. (7-1-06)T

02. Court Order or Voluntary Placement. The child must have been living in a

parent's or relative's home during the month a court order removes the child or during the month a parent or relative voluntarily signs a written agreement with the Department for foster care. (7-1-06)T

03. Custody and Placement. The child's placement and care are the Department's responsibility and the child is living in a licensed foster home, licensed institution, licensed group home, detention center, or in a relative's home approved for the child by the Department. (7-1-06)T

04. IV-E Foster Care and SSI Eligibility. When a child is eligible for both IV-E-Foster Care and SSI, the caretaker relative or social worker must choose the Medicaid coverage group for the child. (7-1-06)T

536. TITLE XIX FOSTER CHILD.
A child living in a foster home, children's agency, or children's institution who does not meet the conditions of Title IV-E Foster Care may be Medicaid eligible if the following conditions are met: (7-1-06)T

01. Age. The foster child is under age twenty-one (21); (7-1-06)T

02. Department Responsibility. The Department assumes full or partial financial responsibility for the child; and (7-1-06)T

03. Income. The child's income cannot exceed two hundred and thirteen dollars ($213) per month. After all applicable income exclusions and disregards have been subtracted from income, an additional seventy dollar ($70) amount is subtracted. (7-1-06)T

537. STATE SUBSIDIZED ADOPTION ASSISTANCE CHILD.
A child in a state subsidized adoptive placement may be Medicaid eligible if the following conditions are met: (7-1-06)T

01. Age. The child is under age twenty-one (21); (7-1-06)T

02. Adoption Assistance. An adoption assistance agreement, other than under Title IV-E, between the state and the adoptive parent(s) is in effect; (7-1-06)T

03. Special Needs. The child has special needs for medical or rehabilitative care that prevent adoptive placement without Medicaid; and (7-1-06)T

04. Medicaid. The child received Medicaid in Idaho prior to the adoption agreement. (7-1-06)T

538. CHILD IN FEDERALLY-SUBSIDIZED ADOPTION ASSISTANCE.
A child in a federally-subsidized adoptive placement under Title IV-E foster care is eligible for Medicaid. No additional conditions must be met. (7-1-06)T

539. THE ADOPTIONS AND SAFE FAMILIES ACT.

The Adoptions and Safe Families Act of 1997 provides health insurance coverage for any child with special needs if they meet the following conditions: (7-1-06)T

01. Adoption Assistance Agreement. The child has an adoption assistance agreement; and(7-1-06)T

02. Special Needs. The State has determined that due to the child's special needs for medical, mental health or rehabilitative care the child cannot be placed with adoptive parents without medical assistance. (7-1-06)T

540. -- 549. (RESERVED).

MEDICAID DIRECT COVERAGE PLANS
(Sections 550 Through 559)

550. MEDICAID DIRECT COVERAGE GROUPS.
Based on the assessment of the participant's health care needs they are enrolled in one (1) of the following plans: (7-1-06)T

01. Medicaid Basic Plan. The Medicaid Basic Plan is similar to private health insurance plans. The services in this plan are described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (7-1-06)T

02. Medicaid Enhanced Plan. The Medicaid Enhanced Plan includes all of the benefits found in the Basic Plan, plus additional benefits to cover needs of people with disabilities or special health needs. The services in this plan are described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-06)T

551. HEALTH ASSESSMENT.
A health assessment is required when a participant moves to the enhanced plan. Children who are receiving services from the Department, in foster care, receiving SSI, infant toddler program and children receiving developmentally delayed services, are eligible for the enhanced plan without the need for the health assessment. (7-1-06)T

552. -- 559. (RESERVED).

PREMIUM ASSISTANCE FOR PRIVATE HEALTH INSURANCE
(Section 560 Through 599)

560. CHOOSING CHILDREN'S ~~*PREMIUM ASSISTANCE*~~ *ACCESS CARD*.
Participants may choose ~~*Premium Assistance*~~ *Children's Access Card* for a child ~~*not currently enrolled in a creditable health insurance plan when the family's income is under one hundred eighty-five percent (185%) of the FPG*~~ *when their countable family income exceeds one-hundred thirty-three percent (133%) and is less than or equal to one-hundred eighty-five percent (185)% of*

the Federal Poverty Guideline for his family size. ~~*(7-1-06)T*~~(7-1-06)T

~~***01. Children's Premium Assistance Eligibility**. All other eligibility requirements in IDAPA 16.03.16, "Premium Assistance," are applicable to children's Premium Assistance unless the rule excludes this coverage group or the child meets the conditions specified in Subsection 525 of these rules. (7-1-06)T***~~

~~***02. Co-pays and Deductibles**. The family is responsible for the co-pays and deductibles required by their private insurance. (7-1-06)T***~~

561. CHILDREN'S ACCESS CARD ELIGIBILITY.
Eligibility requirements described in Sections 520 through 525 and 200 through 296 of these rules are applicable to Children's Access Card. (7-1-06)T

562. CO-PAYS AND DEDUCTIBLES.
The family is responsible for the co-pays and deductibles required by their private insurance. (7-1-06)T

56~~1~~3. -- 599. (RESERVED).

CASE MAINTENANCE REQUIREMENTS
(Sections 600 Through 701)

600. ANNUAL ELIGIBILITY RENEWAL.
Participants must have an annual eligibility review of all eligibility factors. Exceptions to the annual eligibility renewal are listed in Section 601 of these rules. (7-1-06)T

601. EXCEPTIONS TO ANNUAL RENEWAL.
A participant who receives Title XIX or Title XXI through time-limited coverage does not require an annual renewal if: (7-1-06)T

01. Extended Medicaid. A participant who receives Extended Medicaid is eligible as provided in Section 420 of these rules; (7-1-06)T

02. Transitional Medicaid. A participant who receives Transitional Medicaid is eligible as provided in Section 421 of these rules; (7-1-06)T

03. Low Income Pregnant Woman. A participant who receives Medicaid as a Low Income Pregnant Woman is eligible as provided in Section 500 of these rules; and (7-1-06)T

04. Newborn Child of Medicaid-Eligible Mother. A participant receiving Medicaid as the newborn child of a Medicaid-eligible mother is eligible as provided in Section 530 of these rules. (7-1-06)T

602. NON-RENEWAL OF A CHILD'S DIRECT COVERAGE.
A child cannot be renewed for direct coverage if cost-sharing payments are sixty (60) or more

days delinquent as of the last working day of the twelve (12) month continuous eligibility period. A family can reestablish a child's eligibility by paying the premium debt in full. (7-1-06)T

603. -- 609. (RESERVED).

610. REPORTING REQUIREMENTS.
Changes in family circumstances must be reported to the Department. Participants have ten (10) days, from the date the change is known, to report. Report of changes may be made verbally, in writing, through personal contact, telephone, fax, electronic mail, or mail. (7-1-06)T

611. TYPES OF CHANGES THAT MUST BE REPORTED.
Changes in circumstances the participant must report are: (7-1-06)T

01. Name or Address. A name change for any participant must be reported. A change of address or location must be reported; (7-1-06)T

02. Household Composition. Changes in family composition must be reported if a parent or relative caretaker receives Medicaid; (7-1-06)T

03. Marital Status. Marriages or divorces of any family member must be reported if a parent or relative caretaker receives Medicaid; (7-1-06)T

04. New Social Security Number. A Social Security Number (SSN) that is newly assigned to a Medicaid Health Care Assistance program participant must be reported; (7-1-06)T

05. Health Insurance Coverage. Enrollment or disenrollment of a participant in a health insurance plan must be reported.; (7-1-06)T

06. End of Pregnancy. Pregnant participants must report when pregnancy ends; (7-1-06)T

07. Earned Income. Changes in the amount or source of earned income must be reported if a parent or relative caretaker receives Title XIX benefits; (7-1-06)T

08. Unearned Income. Changes in the amount or source of unearned income must be reported if a parent or relative caretaker receives Title XIX benefits; (7-1-06)T

09. Support Income. Changes in the amount of support paid or a change in the ordered amount must be reported if a parent or relative caretaker receives Title XIX benefits; (7-1-06)T

10. Resources. Changes in resources must be reported when a parent, relative caretaker, or pregnant woman receives Title XIX benefits. This includes receipt of money or goods from any source; (7-1-06)T

11. Vehicles. Changes in the number or type of vehicles must be reported if a parent or relative caretaker receives Title XIX benefits; and (7-1-06)T

12. Disability. A family member who becomes disabled or is no longer disabled must be reported if a parent or relative caretaker receives Title XIX benefits. (7-1-06)T

612. PARTICIPANT FAILS TO REPORT EARNED INCOME.
When a parent or relative caretaker who receives Title XIX benefits fails to report a change in earned income, or the change is not reported on time, the earned income disregards are not allowed in the financial determination. (7-1-06)T

613. -- 619. (RESERVED).

620. NOTICE OF CHANGES IN ELIGIBILITY.
The participant must be notified of changes in Health Care Assistance eligibility. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. (7-1-06)T

621. NOTICE OF CHANGE OF PLAN.
Switching from the basic to enhanced plans is allowed within the same month. Advance notice must be given to the participant when there is a decrease in their benefits and he will be switched from the enhanced plan to the basic plan.
(7-1-06)T

622. ADVANCE NOTICE RESPONSIBILITY.
The participant must be notified at least ten (10) calendar days before the effective date of when a reported change results in Health Care Assistance closure. (7-1-06)T

623. ADVANCE NOTICE NOT REQUIRED.
Advance notice is not required when a condition listed in Subsections 623.01 through 623.08 of this rule exists. The participant must be notified no later than the date of the action. (7-1-06)T

01. Death of Participant. The Department has proof of the participant's death.
(7-1-06)T

02. Participant Request. The participant requests closure in writing. (7-1-06)T

03. Participant in Institution. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the state plan. (7-1-06)T

04. Nursing Care. The participant is placed in a nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR). (7-1-06)T

05. Participant Address Unknown. The participant's whereabouts are unknown.
(7-1-06)T

06. Medical Assistance in Another State. A participant is approved for medical assistance in another state. (7-1-06)T

07. Eligible One Month. The participant is eligible for aid only during the calendar month of his application for aid. (7-1-06)T

08. Retroactive Medicaid. The participant's Title XIX or Title XXI eligibility is for a prior period. (7-1-06)T

624. -- 699. (RESERVED).

700. OVERPAYMENTS.
Health Care Assistance overpayments occur when a participant receives benefits during a month they were not eligible. (7-1-06)T

701. RECOVERY OF OVERPAYMENTS.
All Health Care Assistance overpayments are subject to recovery. Overpayments are recovered by direct payment from the participant. (7-1-06)T

01. Notice of Overpayment. The participant must be informed of the Health Care Assistance overpayment and appeal rights. (7-1-06)T

02. Notice of Recovery. The participant must be informed when his Health Care Assistance overpayment is fully recovered. (7-1-06)T

702. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM

DOCKET NO. 16-0304-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2007, 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 56-202, Idaho Code, and 7 CFR.

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 complete text of the proposed rule was published in the October 4, 2006, Idaho Administrative Bulletin, Vol. 06-10, pages 217 through 219. These proposed rule changes will become effective July 1, 2007.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: There may be a slight increase in the number of families approved for food stamps, but there will be no fiscal impact to the state general funds. The Food Stamp Program is 100% federally funded.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Rosie Andueza at (208) 334-5553.

DATED this 3rd day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 56-202, Idaho Code, and 7 CFR.

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 18, 2006.

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:

Families who apply for Food Stamps need reliable transportation in order to seek and maintain employment, to further their education, and to transport their children. Idaho's current policy of counting the value of a family's vehicle in determining their eligibility for Food Stamps often forces the family to sell their reliable vehicles in order to put food on the table to meet their most basic financial needs. Because of Idaho's restrictive rules those who are most hurt by the current rules are two-parent households, working adults, households suffering recent job loss, and those living in rural Idaho.

The proposed changes will exclude one vehicle per adult family member in the Food Stamp household. These changes will promote and support working families in Idaho, especially those families living in rural Idaho with limited access to public transportation.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. There may be a slight increase in the number of families approved for food stamps, but there will be no fiscal impact to the state general funds. The Food Stamp Program is 100% federally funded.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule change is providing a benefit.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Rosie Andueza at (208) 334-5553.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2006.

DATED this 22nd day of August, 2006.

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) 334-6558 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

334. VEHICLES.
~~A~~ Treat any vehicle that is used primarily for transportation and not for recreational use, as described in Subsections 334.01 and 334.02 of these rules. ~~*Vehicles include cars, trucks, vans, motorcycles, boats, snowmobiles, self-propelled motor homes, and aircraft. The average trade-in value in the most recently published NADA guide is the current market value of a vehicle.*~~ The value of any vehicle that is primarily for recreational use counts toward the household's resource limit. ~~*(1-1-95)*~~( )

01. Exclude One Vehicle Per Adult. The value of one (1) vehicle per adult in the Food Stamp household is excluded beginning with the highest valued vehicle. ( )

02. All Other Vehicles Are Subject To Federal Regulations. All other vehicles in the household will have their values counted as provided in 7 CFR 273. ( )

~~***335. TOTALLY EXCLUDED LICENSED VEHICLES.***~~
~~*The Department determines if a vehicle is totally excluded as a resource. If a vehicle is totally excluded, the resource value is not counted against the household's resource limit. Totally excluded licensed vehicles are listed in Subsections 335.01 through 335.07. (3-15-02)*~~

~~***01. Licensed Vehicle Used to Produce Income**. The vehicle must produce annual income consistent with the vehicle's fair market value (FMV). The exclusion applies during temporary unemployment. Examples: Taxi, produce truck, or fishing boat. Licensed vehicles used in self-employed farming by a household member will continue to be excluded as a resource for one (1) year after the farming self-employment stops. (3-15-02)*~~

~~***02. Licensed Vehicle Used for Job-Related Long Distance Travel**. Used for job-related long distance travel by household member, ineligible legal non-citizen, or disqualified person. This does not include commuting to work or training. The exclusion applies during temporary unemployment. (7-1-98)*~~

~~***03. Licensed Vehicle Used as Client's Home**. The vehicle is used as the household's home. (6-1-94)*~~

~~***04. Licensed Vehicle Used to Transport a Disabled Household Member**. Needed to transport any physically disabled household member, physically disabled disqualified person whose resources are counted as available to the household, or physically disabled ineligible alien living in the household. The vehicle is excluded regardless of the purpose of the transportation. This exclusion is limited to one (1) vehicle per physically disabled person. The physical disability may be permanent or temporary. The disability must be verified. (3-15-02)*~~

~~***05. Licensed Vehicle Used to Travel from Job to Job**. Used by migrant farm worker to go from job to job. (6-1-94)*~~

~~***06. Vehicle Used to Carry Fuel or Water**. Used to carry the primary source of fuel for*~~

~~heating or water for home use during the certification period. (7-1-98)~~

~~**07. Licensed Vehicles With No Significant Return**. Proceeds from the sale of the vehicle, minus loans, would be less than one thousand five hundred dollars ($1,500). (3-15-02)~~

~~**336. VEHICLES COUNTED AS A RESOURCE.**~~
~~Determine first if a vehicle is excluded, under Section 335 of these rules, from the equity value test for resources. If the vehicle is not excluded under Section 335, determine the resource value using Subsections 336.01 and 336.02. The resource value for licensed vehicles is determined differently than for unlicensed vehicles. (3-15-02)~~

~~**01. Resource Value of Licensed Vehicles**. Count the resource value of licensed vehicles, if not excluded under Section 335 of these rules, as shown below: (3-15-02)~~

~~**a.** Licensed vehicle per adult household member. Allow one (1) licensed vehicle per adult household member, or ineligible alien, or disqualified household member, whose resources are counted as available to the household, regardless of use. Count the vehicle's fair market value over four thousand six hundred fifty dollars ($4,650) as a resource, regardless of debt. (3-15-02)~~

~~**b.** Licensed vehicle per household member under age eighteen (18), used to commute to work, education, or training, or to seek work. Allow one (1) licensed vehicle per household member, or ineligible alien, or disqualified household member under age eighteen (18), whose resources are counted as available to the household. The vehicle must be used to commute to work, training for work, or to seek work. Count the vehicle's fair market value over four thousand six hundred fifty dollars ($4,650) as a resource, regardless of debt. (3-15-02)~~

~~**c.** Other licensed vehicles. All other licensed vehicles. Count the greater of the client's equity, which is the fair market value minus loans, or the vehicle's fair market value over four thousand six hundred fifty dollars ($4,650) as a resource. (3-15-02)~~

~~**02. Resource Value of Unlicensed Vehicles**. Count the resource value of unlicensed vehicles, not excluded under Section 335 of these rules, as shown in Subsections 336.02.a. through 336.02.c.: (3-15-02)~~

~~**a.** Unlicensed vehicles with no significant return. If the proceeds from the sale of the unlicensed vehicle, minus loans, would be less than one thousand five hundred dollars ($1,500) do not count any resource value. (3-15-02)~~

~~**b.** All other unlicensed vehicles. For all other unlicensed vehicles, working or not working, count the client's equity as a resource. (3-15-02)~~

~~**c.** Unlicensed vehicles on Indian reservation. Treat unlicensed vehicles, driven by tribal members on Indian reservations not requiring licensure as licensed vehicles. Determine the vehicles' resource value by their use.~~

~~(3-15-02)~~

~~**337. COMPUTING VEHICLE FAIR MARKET VALUE.**~~
~~The Department will use an official used car valuations book, such as the NADA Official Used~~

~~*Car Guide, to compute the vehicle's fair market value. Do not add the value of low mileage or optional equipment. Do not add the value of special equipment for a handicapped person. If the household does not agree with the book value, it must provide proof of the vehicle's value from a reliable source such as a car dealer or a bank.* (6-1-94)~~

~~***01. Older Vehicles**. If the vehicle is no longer listed in the NADA Official Used Car Guide, the Department will accept the household's estimate of the vehicle's value. If the Department has reason to question the estimate and if the value of the vehicle will affect eligibility, the household must get an appraisal from a car dealer or produce other evidence of its value. Accept a newspaper advertisement showing the selling price of similar vehicles.* (6-1-94)~~

~~***02. New Vehicles**. If a new vehicle is not listed, get the fair market value by other means. The client may contact a dealer selling that type of vehicle. The dealer's wholesale value is the fair market value. For licensed antique, custom made, or classic vehicles, the household must provide proof of the value from a reliable source.* (6-1-94)~~

~~***03. Multiple Vehicles**. If the household owns more than one (1) vehicle, assess each vehicle individually. Do not add the fair market value of two (2) or more vehicles to reach a total fair market value over four thousand six hundred fifty dollars ($4,650).* (7-1-97)~~

335. -- 337. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

339. ~~*UNLICENSED VEHICLES*~~ (RESERVED).
~~*Count the equity value, the fair market value minus the amount owed, of all unlicensed vehicles, whether or not they are operable.* (6-1-94)~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM

DOCKET NO. 16-0304-0602

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is October 1, 2006. This pending rule has been adopted by the agency and is now pending review by the 2007 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 56-202, Idaho Code, and 7 CFR Parts 271 through 274.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the 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 changes to these rules are concerning clarification of capital gains and how it is calculated.

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 from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the October 4, 2006, Idaho Administrative Bulletin, Vol. 06-10, pages 220 through 242.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Rosie Andueza at (208) 334-5553.

DATED this 15th day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are December 1, 2005 and October 1, 2006.

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 56-202, Idaho Code, and 7 CFR Parts 271 through 274.

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 18, 2006.

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

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

In order to make the Food Stamp Program more cost effective and less error prone, the Department is amending the way income is calculated for individuals applying for food stamps. The federal government requires the state to exclude additional income for military personnel who are deployed to combat zones. These rules are being amended to remove obsolete wording, amend definitions, as well as aligning with federal requirements as follows:

1. **Simplifying income calculations for self-employment and child support income.**
2. **Aligning work requirements and sanctions for non-compliance.**
3. **Excluding the additional military combat pay.**
4. **Amending definitions and removing obsolete wording.**
5. **Aligning time lines with federal requirements.**

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

These rule changes are necessary for compliance with deadlines in governing law for this federal program, and confers a benefit.

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

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes were due to federal law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Rosie Andueza at (208) 334-5553.

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 25, 2006.

DATED this 22nd day of August, 2006.

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) 334-6558 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

007. ~~--008.~~ (RESERVED).

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse or Misconduct." (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

012. DEFINITIONS M THROUGH Z.
For the Food Stamp Program, the following definitions apply: (4-11-06)

01. Migrant Farmworker Household. A migrant farmworker household has a member who travels from community to community to do agricultural work. (4-6-05)

02. Minimum Utility Allowance (MUA). Utility deduction given to a food stamp household that has a cost for one (1) utility. (4-11-06)

03. Nonexempt. A household member who must register for and participate in the JSAP program. A household member who must register for work. (6-1-94)

04. Nonprofit Meal Delivery Service. A political subdivision or a private nonprofit

organization, which prepares and delivers meals, authorized to accept Food Stamps. (6-1-94)

05. Overissuance. The amount Food Stamps issued exceeds the Food Stamps a household was eligible to receive. (6-1-94)

06. Parental Control. Parental control means that an adult household member has a minor in the household who is dependent financially or otherwise on the adult. Minors, emancipated through marriage, are not under parental control. Minors living with children of their own are not under parental control. (4-6-05)

07. Participant. A person who receives Food Stamp benefits. (4-6-05)

08. Program. The Food Stamp Program created under the Food Stamp Act and administered in Idaho by the Department. (6-1-94)

09. Public Assistance. Public assistance means Temporary Assistance for Families in Idaho (TAFI), and Aid to the Aged, Blind, and Disabled (AABD). (4-6-05)

10. Recertification. A recertification is a process for determining ongoing eligibility for Food Stamps. (4-11-06)

11. Retail Food Store. A retail food store, for Food Stamp purposes means: (6-1-94)

a. An establishment, or recognized department of an establishment, or a house-to-house food trade route, whose food sales volume is more than fifty percent (50%) staple food items for home preparation and consumption. (6-1-94)

b. Public or private communal dining facilities and meal delivery services. (6-1-94)

c. Private nonprofit drug addict or alcohol treatment and rehabilitation programs. (6-1-94)

d. Public or private nonprofit group living arrangements. (6-1-94)

e. Public or private nonprofit shelters for battered women and children. (6-1-94)

f. Private nonprofit cooperative food purchasing ventures, including those whose members pay for food prior to the receipt of the food. (6-1-94)

g. A farmers' market. (6-1-94)

h. An approved public or private nonprofit establishment which feeds homeless persons. The establishment must be approved by FCS. (7-1-98)

12. **Sanction**. A penalty period when an individual is ineligible for Food Stamps. (10-1-06)T

1~~2~~3. Seasonal Farmworker Household. A seasonal farmworker household has a

member who does agricultural work of a seasonal or other temporary nature. (4-6-05)

1~~3~~4. **Simplified Reporting Household (SR)**. All households except those in which all members are elderly or disabled. (4-11-06)

1~~4~~5. **Spouse**. Persons who are living together, married or free to marry, and are holding themselves out as man and wife. (4-6-05)

1~~5~~6. **Standard Utility Allowance (SUA)**. Utility deduction given to a food stamp household that has a cost for heating or cooling. (4-11-06)

1~~6~~7. **State**. Any of the fifty (50) States, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands and the Virgin Islands of the United States. (6-1-94)

1~~7~~8. **State Agency**. The Idaho Department of Health and Welfare. (6-1-94)

1~~8~~9. **Student**. An individual between the ages of eighteen (18) and fifty (50), physically and mentally fit, and enrolled at least half-time in an institution of higher education. (6-1-94)

~~19~~20. **Supplemental Security Income (SSI)**. Monthly cash payments under Title XVI of the Social Security Act. Payments include state or federally administered supplements. (4-11-06)

2~~0~~1. **Systematic Alien Verification for Entitlements (SAVE)**. The federal automated system that provides immigration status needed to determine an applicant's eligibility for many public benefits, including Food Stamps. (4-11-06)

2~~1~~2. **Timely Notice**. Notice that is mailed at least ten (10) days before the effective date of an action taken by the Department. (4-6-05)

2~~2~~3. **Twelve Month Contact**. For households that have a twenty-four (24) month certification period, Department staff contact the household during the twelfth month of the certification period for the purpose of determining continued eligibility. (4-6-05)

2~~3~~4. **Tribal General Assistance**. Cash, excluding in-kind assistance, financed by federal, state or local government and provided to cover living expenses or other basic needs. This cash is intended to promote the health and well-being of recipients. (4-11-06)

2~~4~~5. **Verification**. The proof obtained to establish the accuracy of information and the household's eligibility. (6-1-94)

2~~5~~6. **Verified Upon Receipt**. Food stamp benefits are adjusted on open food stamp cases when information is received from "verified upon receipt" sources. Information "verified upon receipt" is received from a manual query or automated system match with the Social Security Administration~~, the Idaho Department of Commerce and Labor for unemployment benefits,~~ or Homeland Security query for citizenship status. ~~(4-11-06)~~(10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

217. NONHOUSEHOLD MEMBERS.
Nonhousehold members are persons not counted in determining Food Stamp household size. Their income and resources do not count toward the Food Stamp household. Nonhousehold members may be eligible as a separate household. Nonhousehold members are listed below: (6-1-94)

01. Roomers. A person who pays for lodging, but not meals. (6-1-94)

02. Live-In Attendants. A person living with a household to provide medical, housekeeping, child care, or other similar services. (6-1-94)

03. Ineligible Students. A person between the ages of eighteen (18) and fifty (50), physically and mentally fit, enrolled at least half-time in an institution of higher education, and not meeting Food Stamp eligibility requirements for students. (6-1-94)

04. Residents of Institutions. A resident of an institution is not a member of the Food Stamp household. A~~n~~ resident of an institution is an ineligible household member because the institution provides the resident over fifty percent (50%) of three (3) meals daily, as part of the normal services. The institution is not allowed to accept ~~coupons~~ Food Stamps. ~~(6-1-94)~~(10-1-06)T

05. Persons Not Purchasing and Preparing Meals. A person sharing living quarters, but not purchasing and preparing meals with the household as standard practice. (6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

237. SANCTIONS FOR FAILURE TO COMPLY WITH JSAP WORK PROGRAM REQUIREMENTS.
When a JSAP participant fails or refuses to comply~~,~~ with work program requirements without good cause, sanctions listed in Subsections 237.01 ~~*through*~~ and 237.02 of these rules must be applied. In determining which sanction to impose, sanctions previously imposed for voluntary quit or reduction in work hours as described in Section 271 of these rules must be considered. ~~(4-5-00)~~(10-1-06)T

01. Noncomplying Household Member. The ~~*noncomplying member*~~ participant who commits the work program violation is excluded as a household member when determining the Food Stamp allotment. The person cannot ~~*get*~~ receive Food Stamps, but his income and resources are counted in the Food Stamp computation for the household. The person ~~*is not eligible for the greater of the sanction periods listed below or becomes exempt from JSAP*~~ must serve a minimum sanction period plus take corrective action to become eligible for Food Stamps again. ~~*End the household's sanction, before the penalty period ends,*~~ If the sanctioned household member becomes exempt from JSAP requirements, end the sanction. ~~(4-5-00)~~(10-1-06)T

a. First ~~*failure to comply*~~ work program violation. ~~*The greater of the date the person corrects the sanction or one (1) month.*~~ A minimum sanction period of one (1) month is imposed. ~~*(7-1-99)*~~(10-1-06)T

b. Second ~~*failure to comply*~~ work program violation. ~~*The greater of the date the person corrects the sanction or three (3) months.*~~ A minimum sanction period of three (3) months is imposed. ~~*(7-1-99)*~~(10-1-06)T

c. Third ~~*failure to comply*~~ and subsequent ~~*failures*~~ work program violations. ~~*The greater of the date the person corrects the sanction or six (6) months.*~~ A minimum sanction period of six (6) months is imposed. ~~*(7-1-99)*~~(10-1-06)T

02. Joins Another Household. If a sanctioned household member leaves the original household and joins another Food Stamp household, treat the sanctioned member as an excluded household member. The person cannot ~~*get*~~ receive Food Stamps, but his income and resources are counted in the Food Stamp computation for the household. The person is excluded for the rest of the sanction period~~*, or*~~ and until ~~*conditions for ending JSAP sanctions are met*~~ corrective actions are taken. ~~*(4-5-00)*~~(10-1-06)T

03. Closure Reason. The household must be informed of the reason for the closure. (10-1-06)T

04. Sanction Notice. The household must be informed of the proposed sanction period. (10-1-06)T

05. Sanction Start. The household must be informed the sanction will begin the first month after timely notice. (10-1-06)T

06. Actions to End Sanction. The household must be informed of the actions the household can take to end the sanction. (10-1-06)T

07. Fair Hearing. The household must be informed of the right to a fair hearing. (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

242. CORRECTIVE ACTION FOR WORK PROGRAMS.
A mandatory participant can requalify for Food Stamps after a sanction. The participant must contact the Department and request an opportunity to comply. The participant must show that failure to comply has ended. Before certifying failure to comply has ended, the Department may require the participant to attend an assigned activity for up to two (2) weeks, to show willingness to comply with ~~*JSAP*~~ work program requirements. ~~*(7-1-98)*~~(10-1-06)T

(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, 200~~2~~5 and ending November 30, 200~~5~~8. ~~(3-20-04)~~(12-1-05)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 his plan. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

271. PENALTY FOR RECIPIENT QUITTING A JOB OR REDUCING WORK HOURS.

If the Department determines a member of the household voluntarily quit a job or reduced work hours, the penalty listed in Subsection 271.01 of these rules must be imposed. Food Stamps must ~~end~~ be reduced, beginning the first month after timely notice. The household must be told the information listed in Subsections 271.02 through 271.06 within ten (10) calendar days of the voluntary quit or reduction in work ruling. When determining the ~~penalty~~ sanction to impose, previous sanctions for noncompliance with JSAP and work registration requirements as described in Section 237 of these rules must be considered. Previous ~~penalties~~ sanctions for ~~applicant~~ recipient voluntary quit or work reduction must also be considered. If the sanctioned household member becomes exempt from JSAP requirements, end the sanction. The voluntary quit sanction does not end if the sanctioned household member becomes exempt due to application or receipt of Unemployment Insurance. ~~(3-15-02)~~(10-1-06)T

01. ~~**Sanction Period**~~ **Non-Complying Household Member**. The ~~member~~ participant who ~~quit or reduced work hours~~ commits the work program violation is excluded as a household member when determining the Food Stamp allotment. The person cannot receive Food Stamps, but his income and resources are counted in the Food Stamp computation for the household. The person ~~is not eligible for the greater of the penalty periods listed below or until he meets one (1) of the conditions to end the penalty~~ must serve a minimum sanction period plus take corrective action to become eligible for Food Stamps again. Corrective action includes: returning to work, increasing work hours to meet the work exemption, or completing required activities with EWS. ~~(3-15-02)~~(10-1-06)T

a. First ~~quit or reduction~~ work program violation. ~~The later in time the person returns to work or increases work hours or one (1) month.~~ A minimum sanction period of one (1) month is imposed. ~~(3-15-02)~~(10-1-06)T

b. Second ~~quit or reduction~~ work program violation. ~~The later in time the person returns to work or increases work hours or three (3) months.~~ A minimum sanction period of three (3) months is imposed. ~~(3-15-02)~~(10-1-06)T

c. Third ~~quit or reduction~~ and subsequent ~~quit or reduction~~ work program violation. ~~The later in time the person returns to work or increases work hours or six (6) months.~~ A minimum sanction period of six (6) months is imposed, ~~(3-15-02)~~(10-1-06)T

02. Joins Another Household. If a sanctioned household member leaves the original household and joins another Food Stamp household, treat the sanctioned member as an excluded household member. The person cannot receive Food Stamps, but his income and resources are counted in the Food Stamp computation for the household. The person is excluded for the rest of the sanction and until corrective actions are taken. (10-1-06)T

0~~2~~3. Closure Reason. The household must be informed of the reason for the closure. (6-1-94)

0~~3~~4. Sanction Notice. The household must be informed of the proposed sanction period. (4-5-00)

0~~4~~5. Sanction Start. The household must be informed the sanction will begin the first month after timely notice. (6-1-94)

0~~5~~6. Actions to End Sanction. The household must be informed of the actions the household can take to end the sanction. (6-1-94)

0~~6~~7. Fair Hearing. The household must be informed of the right to a fair hearing. (6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

275. ENDING VOLUNTARY QUIT ~~OR REDUCTION OF~~ WORK ~~HOURS PENALTY~~ PROGRAM PENALTIES.
Eligibility may be reestablished before the end of the penalty period for an otherwise eligible household member when he meets the conditions in Subsection 275.01 of this rule. Eligibility may be reestablished after a voluntary quit or work reduction penalty period has elapsed for an otherwise eligible household member when he meets a condition in Subsection 275.02 of this rule. ~~(5-3-03)~~(10-1-06)T

01. Ending Voluntary Quit or Reduction Penalty Before the End of the Penalty Period. If the ~~*penalized*~~ sanctioned household member becomes exempt from JSAP requirements, his eligibility for Food Stamps may be reestablished. The voluntary quit penalty does not end if the ~~*penalized*~~ sanctioned household member becomes exempt due to application or receipt of Unemployment Insurance. ~~(5-3-03)~~(10-1-06)T

02. Ending Voluntary Quit or Reduction Penalty After Penalty Period. (5-3-03)

a. ~~*Household member gets a job.*~~ If the ~~*penalized*~~ sanctioned household member gets a new job comparable in salary or hours to the job he quit, his eligibility for Food Stamps may be reestablished. A comparable job may entail fewer hours or a lower net salary than the job which was quit. To be comparable, the hours for the new job cannot be less than thirty (30) hours per week and the salary or earnings for the new job cannot be less than Federal minimum wage multiplied by thirty (30) hours per week. ~~(5-3-03)~~(10-1-06)T

b. ~~*Household member increases hours to more than thirty (30) hours per week.*~~ If the ~~*penalized*~~ sanctioned household member's hours of work are restored to ~~*the average number of*~~ more than thirty (30) hours per week before reduction, his eligibility for Food Stamps may be reestablished. ~~(5-3-03)~~(10-1-06)T

c. A sanctioned household member can requalify for Food Stamps after serving the minimum sanction period and completing corrective action. The participant must contact the Department and request an opportunity to correct the sanction. The Department may require the participant to attend an assigned EWS activity for up to two (2) weeks to show his willingness to comply with work program requirements. (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

323. LUMP SUM RESOURCES.
Nonrecurring lump sum payments are counted as a resource in the month received, unless excluded under these rules. A household using simplified reporting is not required to report changes in resources during a certification period. ~~The~~ A household using change reporting must report the lump sum payment to the Department within ten (10) days of receiving the payment, if their resource limit is exceeded because of the lump sum. If the lump sum along with other resources exceeds the resource limit, ~~the~~ that change reporting household is not eligible for Food Stamps. ~~If resources exceed the limit, the Department will end~~ The Food Stamp~~s~~ case must be closed after timely notice. The household may spend resources down under the limit in the month the lump sum was received. If ~~the~~ resources ~~is~~ are spent down below the resource limit, the household continues to be eligible for Food Stamps. The household must still report receipt of the lump sum payment within ten (10) days. Some lump sum payments are listed below:
~~(4-11-06)~~(10-1-06)T

01. Retroactive Payments. Retroactive payments from: (6-1-94)

a. Social Security. (6-1-94)

b. SSI. (6-1-94)

c. Public Assistance. (6-1-94)

d. Railroad Retirement Benefits. (6-1-94)

e. Unemployment Compensation Benefits. (6-1-94)

f. Child Support. (10-1-06)T

02. Insurance. Insurance settlements. (6-1-94)

03. Refunds. Income tax refunds, rebates, or credits. (6-1-94)

~~**04. Earned Income Tax Credit (EITC)**. Single earned income tax credit payments received at the end of the tax year. (6-1-94)~~

0~~5~~4. Property Payments. Lump sum payment from sale of property. Contract payments from the sale of property are counted as income. (6-1-94)

0~~6~~5. Security Deposits. Refunds of security deposits on rental property or utilities. (6-1-94)

0~~7~~6. Disability Pension. Annual adjustment payments in VA disability pensions. (6-1-94)

0~~8~~7. Vacation Pay. Vacation pay, withdrawn in one lump sum by a terminated

employee. (6-1-94)

0~~9~~8. **Military Bonus**. Military re-enlistment bonuses. (6-1-94)

~~1~~09. **Readjustment Pay**. Job Corps readjustment pay. (6-1-94)

1~~1~~0. **Severance Pay**. Severance pay, paid in one (1) lump sum to a former employee. (6-1-94)

1~~2~~1. **TAFI One-Time Cash Payment**. The one-time TAFI cash diversion payment. (4-5-00)

(BREAK IN CONTINUITY OF SECTIONS)

402. UNEARNED INCOME.
Unearned income includes, but is not limited to income listed below: (6-1-94)

01. **Public Assistance (PA)**. Payments from SSI, TAFI, AABD, GA, or other Public Assistance programs are unearned income. (7-1-98)

02. **Retirement Income**. Payments from annuities, pensions, and retirement are unearned income. Old age, survivors, or Social Security benefits are unearned income. (6-1-94)

03. **Strike Benefits**. Strike benefits are unearned income. (6-1-94)

04. **Veteran's Benefits**. Veteran's benefits are unearned income. (6-1-94)

05. **Disability Income**. Disability benefits are unearned income. (6-1-94)

06. **Workers' Compensation**. Workers' Compensation is unearned income. (6-1-94)

07. **Unemployment Insurance**. Unemployment Insurance is unearned income. (6-1-94)

08. **Contributions**. Contributions are unearned income. (6-1-94)

09. **Rental Property Income**. Rental property income, minus the cost of doing business, is unearned income if a household member is not managing the property at least twenty (20) hours per week. (6-1-94)

10. **Support Payments**. Support payments, including child support payments, are unearned income. (6-1-94)

11. **Alimony**. Alimony payments are unearned income. (6-1-94)

12. Education Benefits. Educational scholarships, grants, fellowships, deferred payment loans, and veteran's educational benefits exceeding excluded amounts are unearned income. (6-1-94)

13. Government Sponsored Program Payments. Payments from government sponsored programs are unearned income. (6-1-94)

14. Dividends, Interest, and Royalties. Dividends, interest, and royalties are unearned income. (6-1-94)

15. Contract Income. Contract income from the sale of property is counted as unearned income. (6-1-94)

16. Funds From Trusts. Monies withdrawn from trusts exempt as a resource are unearned income. Dividends paid or dividends that could be paid from trusts exempt as a resource are unearned income. (7-1-97)

17. Recurring Lump Sum Payments. Recurring lump sum payments are unearned income. (7-1-98)

18. Prizes. Cash prizes, gifts and lottery winnings are unearned income. (6-1-94)

19. Diverted Support or Alimony. Child support or alimony payments, diverted by the provider to a third party, to pay a household expense are unearned income. (6-1-94)

~~***20. HUD Payments for Utilities**. Housing and Urban Development (HUD) payments for utility costs, made directly to the household or jointly to the household and utility company, are unearned income. (6-1-94)***~~

2~~1~~0. Agent Orange Payments. Payments made under the Agent Orange Act of 1991 and disbursed by the U.S. Treasury are unearned income. (6-1-94)

2~~2~~1. Garnishments. Garnishments from unearned income are unearned income. (6-1-94)

2~~3~~2. Tribal Gaming Income. Tribal gaming income is unearned income. The participant can choose to count the income in the month received, or prorate the income over a twelve (12) month period. (4-5-00)

2~~4~~3. Other Monetary Benefits. Any monetary benefit, not otherwise counted or excluded, is unearned income. (6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

406. INCOME EXCLUDED BY FEDERAL LAW.

Income listed in Section 406 is excluded by Federal law when computing Food Stamp eligibility: (3-15-02)

01. P.L. 91-646. Reimbursements under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policy Act of 1970. (6-1-94)

02. P.L. 92-203. Funds from the Alaska Native Claims Settlement Act. (6-1-94)

03. P.L. 93-113 RSVP. Payments under Title I and Title II, "Retired Senior Volunteer Program" (RSVP), the Foster Grandparents Program and the Domestic Volunteer Services Act of 1973. (6-1-94)

04. P.L. 93-134 as Amended by P.L. 103-66. Effective January 1, 1994, up to two thousand dollars ($2,000) per calendar year of payments derived from interest of individual Indians in trust or restricted lands. (6-1-94)

05. P.L. 93-288, P.L. 100-707 Disaster Relief. Payments from Disaster Relief and Emergency Assistance Disaster Relief Act. (6-1-94)

06. P.L. 93-531. Relocation assistance to Navajo and Hopi tribal members. (6-1-94)

07. P.L. 94-114. The submarginal lands held in trust by the U.S. for certain Indian tribal members. (6-1-94)

08. P.L. 94-189. Funds from the Sac and Fox Indian Claims Agreement. (6-1-94)

09. P.L. 94-540. Funds to the Grand River Band of Ottawa Indians. (6-1-94)

10. P.L. 95-433. Funds to the Confederated Tribes and Bands of the Yakima Indian Nation and the Apache Tribe of the Mescalero Reservation from the Indian Claims Commission. (6-1-94)

11. P.L. 96-420. Funds to the Passamaquoddy Tribe and Penobscot Nation funds paid under the Maine Indian Claims Settlement Act of 1980. (6-1-94)

12. P.L. 105-220 WIA. All earned and unearned income received from the Workforce Investment Act (WIA) of 1998, except for earned income received from taking part in on-the-job training programs. (3-15-02)

13. P.L. 97-365 and P.L. 98-64. Up to two thousand dollars ($2,000) of any per capita payment, and any purchases made with such payment, from funds held in trust by the Secretary of the Interior. (6-1-94)

14. P.L. 97-403. Funds to the Turtle Mountain Band of Chippewas, Arizona. (6-1-94)

15. P.L. 97-408. Funds to the Blackfeet, Gros Ventre, and Assiniboine Tribes, Montana. Funds to the Papago Tribe, Arizona. (6-1-94)

16. **P.L. 98-123**. Funds to the Red Lake Band of Chippewa Indians. (6-1-94)

17. **P.L. 98-500**. Funds from the Old Age Assistance Claims Settlement Act, provided to heirs of deceased Indians, except for per capita shares over two thousand dollars ($2,000). (6-1-94)

18. **P.L. 99-264**. Funds to the White Earth Band of Chippewa Indians, Minnesota. (6-1-94)

19. **P.L. 99-346**. Funds to the Saginaw Chippewa Indian Tribe, Michigan. (6-1-94)

20. **P.L. 100-175**. Effective October 1, 1987, payments received by persons age fifty-five (55) and older under Title V, "Senior Community Service Employment Program". (6-1-94)

21. **P.L. 100-435 WIC**. Benefits from the Women, Infants, and Children (WIC) Program. (6-1-94)

22. **P.L. 100-435 Section 403**. Payments or reimbursements for work related or child care expenses made under an employment, education, or training program under Title IV-A of the Social Security Act after September 19, 1988. ~~(6-1-94)~~(10-1-06)T

23. **P.L. 100-435 Section 404**. Payments made to a JSAP participant for work, training, or education-related expenses or for dependent care. ~~(6-1-94)~~(10-1-06)T

24. **P.L. 101-41**. Funds to the Puyallup Tribe of Indians, Washington. (6-1-94)

25. **P.L. 101-277**. Payments to the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukae Tribe of Florida, and the Independent Seminole Indians of Florida. (6-1-94)

26. **P.L. 101-426**. Payments made under the Radiation Exposure Compensation Act. (6-1-94)

27. **P.L. 101-508**. At-risk child care payments. (6-1-94)

28. **P.L. 101-610 and P.L. 103-82**. Allowances, earnings and payments to persons participating in programs under the National and Community Services Act. The exclusion applies to all payments made under the AmeriCorps Program. (7-1-99)

29. **P.L. 102-237**. Amounts needed for attainment of a Plan for Achieving Self-Support (PASS) under Title XVI of the Social Security Act. (6-1-94)

30. **P.L. 102-325**. Educational income authorized under the BIA student assistance programs and under Title IV of the Higher Education Amendments of 1992. (6-1-94)

31. **P.L. 103-286**. Effective 08-01-94, payments made to victims of Nazi persecution. (1-1-95)

32. **P.L. 103-436**. Payments to the Confederated Tribes of the Colville Reservation for the Grand Coulee Dam Settlement. (7-1-97)

33. **P.L. 104-204**. Payments to children with spina bifida born to Vietnam veterans. (7-1-99)

34. **Agent Orange Settlement Fund**. Product liability payments, made by Aetna Life and Casualty from the Agent Orange Settlement Fund. Any other fund for the settlement of Agent Orange liability litigation. (6-1-94)

35. **Civil Liberties Act of 1988**. Restitution payments to persons of Japanese ancestry who were evacuated, relocated and interned during World War II as a result of government action. These payments are also excluded when paid to the statutory heirs of deceased internees. (6-1-94)

36. **Negative Utility Allowance**. Negative utility payments from HUD and FmHA. (8-1-94)

37. **Energy Assistance**. Payments from Federal energy assistance, including insulation and weatherization payments. (7-1-98)

38. **SSI Payments Under Zebley v. Sullivan Ruling**. Retroactive lump sum SSI payments, for childhood disability, paid as a result of the Zebley v. Sullivan ruling. The payments are excluded resources for six (6) months from receipt. (6-1-94)

39. **VISTA Payments**. Payments under Title I, VISTA, University Year for Action and Urban Crime Prevention Program to volunteers who were receiving Food Stamps or public assistance when they joined the program. Payments to volunteers who were getting an income exclusion for a VISTA or other Title I allowance before the Food Stamp Act of 1977. Temporary breaks in participation do not alter the exclusion. (6-1-94)

40. **Crime Act of 1984 as Amended by P.L. 103-322**. Payments from a crime victim compensation program. (7-1-99)

41. **Combat Pay, P.L. 108-447**. Additional pay received by military personnel as a result of deployment to a combat zone. (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

426. SELF-EMPLOYMENT INCOME.
~~*Net self-employment income is computed by subtracting allowable business expenses from self-employment earnings. Actual, not rounded, figures are used.*~~ The Idaho Food Stamp Program recognizes two (2) types of self-employment businesses. ~~*(6-1-94)*~~(10-1-06)T

01. **Farming Self-Employment**. The farmer must receive or expect to receive an annual gross income of one thousand dollars ($1000) or more to be a self-employed farmer.

(10-1-06)T

02. **Non-Farming Self Employment**. All other self-employment businesses. (10-1-06)T

427. COMPUTING NON-FARMING SELF-EMPLOYMENT INCOME STANDARD DEDUCTION.
Net self-employment income for a non-farming business is computed by subtracting fifty percent (50%) from the gross income as an allowable standard deduction from non-farming self-employment earnings. (10-1-06)T

42~~7~~8. WHEN NON-FARMING SELF-EMPLOYMENT INCOME MUST BE AVERAGED OVER TWELVE MONTHS.
~~*Self-employment income, even if received within a short period, must be averaged over a twelve (12) month period if it is the household's annual support. The*~~ Non-farming self-employment income, if it is considered annual support by the household, must be averaged over a twelve (12) month period, even if it is received over a short time period and the household ~~*gets*~~ receives income from other sources in addition to self-employment. ~~*Self-employment income received on a monthly basis, which is a household's annual support, is averaged over a twelve (12) month period.*~~ ~~*(6-1-94)*~~(10-1-06)T

42~~8~~9. AVERAGING SEASONAL NON-FARMING SELF-EMPLOYED INCOME.
Seasonal non-farming self-employed households ~~*get*~~ receive income from self-employment during part of the year. Self-employment income intended to meet the household's needs for only part of the year must be averaged over the period of time the income is intended to cover. ~~*(6-1-94)*~~(10-1-06)T

~~***429. WHEN SELF-EMPLOYMENT INCOME MUST BE PROJECTED.***~~
~~*If the household has a large increase or decrease in self-employment income, the self-employment income must not be averaged using past income. The Department must project self-employment income for the coming year using Subsections 429.01 through 429.03. Add the net self-employment income to any other earned income received by the household.* (6-1-94)~~

~~***01. Step 1.*** (6-1-94)~~

~~***a.*** *Self-employed less than one (1) year: If a self-employment enterprise has been in existence for less than a year, the income is averaged over the period the business has been in operation. If no income fluctuations are expected, the average monthly amount is projected for the coming year.* (6-1-94)~~

~~***b.*** *Self-employed for a short time: If the business has been in operation for less than a year and there is not enough information to make a projection, the household may be certified for less than a year. When the business has been in operation long enough to establish an average income, a new projection may be made.* (6-1-94)~~

~~***02. Step 2 -- Costs.*** *Subtract the cost of producing the self-employment income. The cost of producing the self-employment income is calculated by projecting the monthly costs of producing the self-employment income.* (6-1-94)~~

~~*03. Step 3 -- Capital Gains. Capital gains are the increase in value of an asset between the time it is bought and the time it is sold. Add capital gains the household predicts it will get in the next twelve (12) months from self-employment assets.* (6-1-94)~~

~~*a. Start projecting capital gains the date the application is filed.* (6-1-94)~~

~~*b. Divide the yearly total projected capital gains by twelve (12). The monthly amount is used during the next twelve (12) months.* (6-1-94)~~

~~*c. A new average monthly amount must be calculated for this twelve (12) month period if the capital gains changes.* (6-1-94)~~

~~*04. Step 4 -- Add Capital Gains. Add the projected monthly capital gains to the projected self-employment income.* (6-1-94)~~

430. COMPUTING NON-FARMING SELF-EMPLOYMENT INCOME.
~~*Procedures and rules for computing self-employment income are listed in Subsections 430.01 through 430.04. Self-employment income of households owning and operating a commercial boarding house is computed using Subsections 430.01 through 430.04. Add the net self-employment income to any other earned income received by the household.*~~ Compute non-farming self-employment income by adding projected monthly earnings to projected capital gains and subtracting the self-employment standard deduction. ~~(6-1-94)~~(10-1-06)T

01. ~~*Step 1 -- Add Self-Employment Income. For the self-employment income period, add all gross self-employment income.*~~ **Determine Monthly Earnings**. If no income fluctuations are expected, the average monthly amount is projected for the certification period. If past earnings are not reflective of expected future earnings, make a proportionate adjustment to the expected monthly earnings. Determine the monthly earnings by the using one (1) of the following: ~~(6-1-94)~~(10-1-06)T

a. If tax returns are available, use the information on the return to determine an appropriate average monthly earnings amount. Do not assume that the tax return reflects a full twelve (12) months of self-employment. (10-1-06)T

b. If no tax return is available, the self-employment income is averaged over the period of time the enterprise has been in operation, (10-1-06)T

02. ~~***Step 2 --***~~ **Add** ~~***Self-Employment***~~ **Monthly Capital Gains Income**. Capital gains ~~*are income is the increase in value of an asset between the time it is bought and the time it is sold*~~ *include profit from the sale or transfer of capital assets used in self-employment*. ~~*Capital gains include profit from the sale or transfer of capital assets used in self-employment.*~~ *Calculate capital gains using the federal income tax method.* ~~*Count the full amount of the capital gains as income for Food Stamps.*~~ Determine if the household expects to receive any capital gains income from self-employment assets during the certification period. Add this amount to the monthly earnings as determined in Subsection 430.01 of these rules to determine the gross monthly income. ~~(3-15-02)(10-1-06)T~~(10-1-06)T

03. ~~***Step 3 --***~~ **Subtract** ~~***Costs***~~ **Non-Farming Self-Employment Standard Deduction**. ~~*Subtract the cost of producing the self-employment income. The household must have proof of costs. Allowable costs of producing self-employment income include, but are not limited to:*~~ Subtract fifty percent (50%) of the gross monthly income as a self-employment standard deduction. This is the projected non-farming self-employment monthly income. ~~*(6-1-94)*~~(10-1-06)T

~~***a.*** *The cost of labor paid to nonhousehold members.* *(6-1-94)*~~

~~***b.*** *The cost of stock.* *(6-1-94)*~~

~~***c.*** *The cost of raw material.* *(3-15-02)*~~

~~***d.*** *The cost for rent and utilities, advertising, shipping and legal fees.* *(6-1-94)*~~

~~***e.*** *The cost of seed and fertilizer.* *(6-1-94)*~~

~~***f.*** *Interest paid to purchase income-producing property, including real estate.* *(6-1-94)*~~

~~***g.*** *Insurance premiums.* *(6-1-94)*~~

~~***h.*** *Taxes paid on income-producing property.* *(6-1-94)*~~

~~***i.*** *Transportation, when a vehicle is an integral part of business activity.* *(6-1-94)*~~

~~***j.*** *Payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable goods.* *(3-15-02)*~~

~~***04.*** ***Costs of Doing Business****. The following items are not allowed as costs of doing business:* *(6-1-94)*~~

~~***a.*** *Net losses from previous periods.* *(6-1-94)*~~

~~***b.*** *Federal, State, and local income taxes.* *(6-1-94)*~~

~~***c.*** *Money set aside for retirement.* *(6-1-94)*~~

~~***d.*** *Work-related personal expenses such as transportation to and from work.* *(6-1-94)*~~

~~***e.*** *Depreciation.* *(6-1-94)*~~

~~***f.*** *Any costs exceeding the payment a household gets from a boarder for lodging and meals.* *(3-15-02)*~~

~~***05.*** ***Step 4 -- Average Income****. Divide the self-employment income by the number of months the income will be averaged.* *(6-1-94)*~~

~~***431. COMPUTING NON-COMMERCIAL BOARDER INCOME.***~~
~~*Income received from boarders, by a household not owning and operating a commercial boarding house, is computed using Subsections 431.01 through 431.03. Add the net self-employment income from the boarder to any other earned income received by the household.* (6-1-94)~~

~~***01. Step 1 -- Add Income**. Add income from the boarder. Income from boarders includes all direct payments to the household for room and meals. Income includes contributions to the household's shelter expenses if paid directly to the household. Shelter expenses paid directly by boarders to someone outside the household are not income to the household.* (6-1-94)~~

~~***02. Step 2 -- Subtract Costs**. Subtract cost of doing business. Cost is computed by:* (6-1-94)~~

~~***a.** Using the amount of the thrifty food plan for a household size equal to the number of boarders.* (6-1-94)~~

~~***b.** If the actual cost exceeds the thrifty food plan, count the actual documented cost of providing room and meals. If actual costs are used, only separate and identifiable costs of providing room and meals to boarders are counted.* (6-1-94)~~

~~***c.** If the cost of doing business exceeds the payment the household receives from the boarder for lodging and meals, the negative balance must not be applied to other income.* (6-1-94)~~

~~***03. Step 3 -- Use Remaining Income**. The remaining income is used in computing Food Stamp benefits.* (6-1-94)~~

431. COMPUTING FARMING SELF-EMPLOYMENT INCOME.
For farming self-employment, compute net income by subtracting allowable expenses from the gross income as follows in Subsections 431.01 through 431.04 of these rules. (10-1-06)T

01. Determine Monthly Earnings. If no income fluctuations are expected, the average monthly amount is projected for the certification period. If past earnings are not reflective of expected future earnings, make a proportionate adjustment to the expected monthly earnings. Determine the monthly earnings by using one (1) of the following: (10-1-06)T

a. If tax returns are available, use the information on the return to determine an appropriate average monthly earnings amount. Do not assume that the tax return reflects a full twelve (12) months of farming self-employment. (10-1-06)T

b. If no tax return is available, the farming self-employment income is averaged over the period of time the enterprise has been in operation, (10-1-06)T

02. Add Monthly Capital Gains Income. Capital gains ~~*income is the increase in the value of an asset between the time it was bought and the time it was sold*~~ *include profit from the sale or transfer of capital assets used in self-employment*. *Calculate capital gains using the federal income tax method.* Determine if the household expects to receive any capital gains income from farming self-employment assets during the certification period. Add this amount to

the monthly earnings as determined in Subsection 431.01 of these rules to determine the gross monthly income. ~~(10-1-06)T~~(10-1-06)T

03. Subtract Allowable Expenses. Subtract any allowable expenses for farming self-employment, except those listed in Subsection 431.04 of these rules for expenses that are not allowed. This is the projected farming self-employment monthly income. (10-1-06)T

04. Costs Not Allowed for Farming Self-Employment Expenses. The following items are not allowed as costs of doing business and may not be subtracted from the farming self-employment income. (10-1-06)T

a. Net losses from previous certification periods; (10-1-06)T

b. Federal, State, and local income taxes; (10-1-06)T

c. Money set aside for retirement; (10-1-06)T

d. Work related personal expenses such as transportation to and from work; and (10-1-06)T

e. Depreciation. (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

501. INITIAL CHANGES IN FOOD STAMP CASE.
Act on changes in household circumstances found during the application or the initial interview. (6-1-94)

01. Anticipated Changes. A household can be eligible in the application month, but not eligible the month after the application month because of expected changes in circumstances. The household may not be eligible for the application month, but eligible for the next month. The same application form is used for the denial and the next month's eligibility determination. (6-1-94)

02. Food Stamps for the Application Month. The household's Food Stamp issuance for the application month may differ from its issuance in later months. (6-1-94)

03. Food Stamp Issuance Changes. ~~*The household's Food Stamp issuance may vary month to month, within the certification period, to reflect expected changes.*~~ The Department will make changes to the household's Food Stamp issuance when it is required to act on a change. ~~(6-1-94)~~(10-1-06)T

04. Change Before Certification. If a household reports a change in household circumstances before certification and the Department can act on the change, include the reported information in determining Food Stamp eligibility and amount. (6-1-94)

05. Change After Certification. If a household reports a change after the initial Food Stamp benefit has been paid, the Department must act on the change if it was required to be reported or would increase the household's Food Stamp benefits under these rules. Changes in the household's expenses will not be acted upon until recertification. Notice of the change must be given to the Food Stamp household. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

509. TYPES OF INCOME TO BE AVERAGED.
Types of income to be averaged are listed below. Income for a destitute migrant~~/~~ or seasonal farm worker household is not averaged. ~~(6-1-94)~~(10-1-06)T

01. Self-Employment Income. Average self-employment income. (6-1-94)

02. Contract Income. Average contract income over the period of the contract, if not received on an hourly or piecework basis. Households with averaged contract income include school employees, share croppers and farmers. These households do not include migrants or seasonal farm workers. (6-1-94)

03. Scholarships or Education Loans. Average scholarship, deferred educational loan, or other educational grant income, after exclusions, over the period of intended use. Scholarships or education loans may cover part of a month. A partial month is counted as a whole month to determine the period of intended use. (6-1-94)

a. If education benefits are received in the middle of the coverage period average them over the entire period, after deducting allowable expenses. Count the average monthly amount for only the remaining months in the period covered. No overissuance exists for the previous months. (6-1-94)

b. If education costs are incurred and verified after the first month of the school term, average the expenses over the entire period of intended use. Deduct only the average monthly amount for the remaining months in the period of intended use. (6-1-94)

04. Income Received Less Often Than Monthly. When receipt of income is less often than monthly, the anticipated income can be averaged over the period intended to cover to determine the average monthly income. (6-1-94)

05. Child Support. Child support income can be averaged to make a valid projection for ongoing income. (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

535. MEDICAL EXPENSES.
Medical expenses over thirty-five dollars ($35), for elderly or disabled household members, are deducted from the household income. Allowable medical expense deductions are listed in Subsection 535.01 through 535.14 of these rules. The household must provide proof of the incurred or anticipated cost before a deduction is allowed. ~~(4-11-06)~~(10-1-06)T

01. Medical and Dental Services. Services must be performed by licensed practitioners, physicians, dentists, podiatrists, or other qualified health professionals. Other qualified health professionals include registered nurses, nurse practitioners, licensed physical therapists and licensed chiropractors. (6-1-94)

02. Psychotherapy and Rehabilitation Services. Services must be performed by licensed psychiatrists, licensed clinical psychologists, licensed practitioners, physicians or other qualified health professionals. (6-1-94)

03. Hospital or Outpatient Treatment. Hospital or outpatient treatment includes expenses for hospital, nursing care, State licensed nursing home care, and care to a person immediately before entering a hospital or nursing home. (4-6-05)

04. Prescription Drugs. Prescription drugs and prescribed over-the-counter medication including insulin. (6-1-94)

05. Medical Supplies and Sickroom Equipment. Medical supplies and sickroom equipment including rental or other equipment. (6-1-94)

06. Health Insurance. Health and hospitalization insurance premiums. These do not include health and accident policies payable in a lump sum for death or dismemberment. These do not include income maintenance policies to make mortgage or loan payments while a beneficiary is disabled. (6-1-94)

07. Medicare Premiums. Medicare premiums related to coverage under Title XVIII of the Social Security Act. (6-1-94)

08. Cost-Sharing or Spend-Down Expenses. Cost-sharing or spend-down expenses incurred by Medicaid recipients. (6-1-94)

09. Artificial Devices. Dentures, hearing aids, and prostheses. (6-1-94)

10. Guide Dog. Expenses incurred buying and caring for any animal trained and routinely used to help a disabled person. Expenses include costs for dog food, training, and veterinarian services. (4-6-05)

11. Eyeglasses. Expenses for eye examinations and prescribed eyeglasses. (4-6-05)

12. Transportation and Lodging. Reasonable transportation and lodging expenses

incurred to get medical services. (4-6-05)

13. Attendant Care. Attendant care costs necessary due to age, disability, or illness. If attendant care costs qualify for both the excess medical and dependent care expense deductions, the cost is treated as a medical expense. (4-6-05)

14. Attendant Meals. One hundred nineteen dollars ($119) per month are deducted if the household provides most of the attendant's meals. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

542. COSTS ALLOWED FOR SHELTER DEDUCTION.
Shelter costs are current charges for the shelter occupied by the household. Shelter costs include costs for the home temporarily not occupied because of employment or training away from home or illness. The costs allowed for the shelter deduction are listed below: (6-1-94)

01. House Payments. Mortgages, second mortgages, mortgage fees, home equity loans, and land payments. (4-6-05)

02. Rent. Rent and space rent. (6-1-94)

03. Homeless Shelter Deduction. The homeless shelter deduction is allowed for homeless households with some shelter expenses. It is established by FNS and may be found under http://www.fns.usda.gov/fsp/government/cola.htm. This deduction must not be used in combination with other costs allowed for shelter deduction. (4-11-06)

04. Condominium Fees. The entire condominium fee, including fees for maintenance of the structure and the grounds. (3-30-01)

05. Loan Payments. Loan repayments for the purchase of a mobile or motor home, including interest. (6-1-94)

06. Taxes And Insurance. Property taxes, state and local assessments, and insurance on the ~~*structure*~~ property. This also includes insurance on a vehicle used as a residence.
~~*(4-6-05)*~~(10-1-06)T

07. Utilities. Only one (1) utility allowance (SUA, LUA, or MUA) may be used for a household. The costs used to determine the utility allowance are: heating, cooling, cooking fuel, electricity, the basic service fee for one (1) telephone (including wire maintenance fees, subscriber line charges, relay center surcharges, 911 fees, and basic service for a cellular phone), water, sewer, garbage and trash collection, well installation and maintenance, septic tank system installation and maintenance, and fees for initial utility installation. One-time deposits cannot be included. (4-6-05)

08. Vehicle Payments. Payments for vehicles used as the primary residence for the

household. (6-1-94)

09. Costs for Home Repairs. Nonreimbursable costs to repair a home damaged or destroyed by a natural disaster such as a fire or flood or earthquake. (6-1-94)

10. Home Temporarily Not Occupied. Shelter costs for the home temporarily not occupied because of employment, training away from home, illness, or abandonment caused by a natural disaster or casualty loss. This shelter cost may be in addition to the shelter cost for the home the household currently occupies. To receive the shelter deduction for a vacated home: (4-6-05)

a. The household must intend to return; (4-6-05)

b. Current occupants must not be claiming Food Stamp shelter costs; and (4-6-05)

c. The home must not be leased or rented. (6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

576. CERTIFICATION PERIODS.
A certification period must be assigned for each household. Households must be assigned a certification period based on household circumstances at the time of application approval or recertification in accordance with 7 CFR 273.10(f) and 273.12, and the Farm Bill under Title IV, Subtitle A - Food Stamp Programs, Section 4109, regarding the state option to reduce reporting requirements. ~~*Households can change certification periods and reporting type only at the time of application approval or recertification.*~~ At the end of each certification period, entitlement to Food Stamps ends. Further eligibility starts only upon recertification based upon a newly completed application, an interview, and verification. The certification period cannot be lengthened nor can benefits be continued beyond the end of a certification period without a new determination of eligibility. ~~*(4-6-05)*~~(10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

694. COLLECTING CLAIMS.
The Department collects payment for claims using the methods listed in Subsections 695.01 through 695.0~~6~~5 of these rules. ~~*(3-15-02)*~~(10-01-06)T

01. Allotment Reduction. The Department reduces the Food Stamp allotment to collect the claim. (3-15-02)

a. For an IPV claim, the allotment reduction limit is the greater of twenty dollars ($20) per month or twenty percent (20%) of the household's monthly allotment. (3-15-02)

b. For an IHE or AE claim, the allotment reduction limit is the greater of ten dollars ($10) per month or ten percent (10%) of the household's monthly allotment. The household can agree to a higher amount. (3-15-02)

c. The Department does not reduce the initial month's Food Stamps, unless the household agrees to this reduction. (3-15-02)

02. Repayment from EBT Account. The household pays the claim from its Electronic Benefit Transfer (EBT) account. (3-15-02)

03. Cash, Check, or Money Order. Payment by cash, check, or money order. (3-15-02)

~~***04. Paper Food Coupons**. Payment by paper Food Coupons. (3-15-02)*~~

0~~5~~4. Household Performing Public Service. Payment by public service as ordered by a court, specifically as payment of a claim. (3-15-02)

0~~6~~5. Collection by Treasury Offset Program (TOP). The Department submits claims delinquent for one hundred and eighty (180) days, or more, for collection through TOP. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

698. INTENTIONAL PROGRAM VIOLATION (IPV).
An IPV includes the actions listed in Subsections 698.01 through 698.03 of these rules. The client must intentionally, knowingly, and willfully commit a program violation. (3-15-02)

01. False Statement. A person makes a false statement to the Department, either orally or in writing, to get Food Stamps. (6-1-94)

02. Misleading Statement. A person makes a misleading statement to the Department, either orally or in writing, to get Food Stamps. (6-1-94)

03. Misrepresenting. A person misrepresents facts to the Department, either orally or in writing, to get Food Stamps. (6-1-94)

04. Concealing. A person conceals or withholds facts to get Food Stamps. (6-1-94)

05. Violation of Regulations. A person commits any act violating the Food Stamp Act, ~~*or*~~ Federal regulations~~.~~, ~~*A person commits any act violating*~~ or State Food Stamp regulations. The violation may relate to ~~*Food Stamps or Authorization to Participate (ATP)*~~ use, presentation, transfer, acquisition, receipt, or possession of Food Stamps. ~~*(3-15-02)*~~(10-1-06)T

06. Trafficking in Food Stamps. Trafficking in Food Stamps means the buying or

selling of ~~*coupons, ATP cards*~~ Food Stamps or other benefit instruments for cash, or consideration other than eligible food. Trafficking includes the exchange of firearms, ammunition, explosives, or controlled substances, as defined in Section 802 of Title 21, USC ~~*Code*~~, for ~~*coupons or other*~~ benefit instruments. ~~*(3-15-02)*~~(10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

793. NARCOTIC ADDICT AND ALCOHOLIC TREATMENT CENTERS.
Narcotic addicts and their children residing in a treatment center may qualify for Food Stamps. Alcoholics and their children residing in a treatment center may qualify for Food Stamps. Food Stamp rules for residents in a drug addiction or alcohol treatment and rehabilitation program lasting at least thirty (30) days are listed below: (9-1-94)

01. Optional Appointment of Authorized Representative. Unless the household requests it, the center will not be made authorized representative on the household's own EBT card for months of benefits received while not in the center. (4-5-00)

02. Center Provides Certification List. Each month, each center must give the Field Office a list of current client residents. The list's accuracy must be certified in writing by the center manager or designee. The Department must conduct random on-site visits to assure list accuracy. If the list is not accurate, or the Department fails to act on the change, the Department may transfer the Food Stamp amount from the center's account to the household's Food Stamp account, for the months the household was not living in the center. (4-5-00)

03. Resident and Nonresident Clients. Eligible narcotic addicts or alcoholics must be certified as one (1) person households. Eligible narcotic addicts with children or alcoholics with children residing in a center must be certified as one (1) household. Clients not residing at the treatment center are certified under normal procedures. (9-1-94)

04. Food Stamp Basis. Eligibility and Food Stamp amounts must be based on income and resources. (6-1-94)

05. Work Registration. Resident clients are exempt from work registration. (6-1-94)

06. Expedited Processing. When the application needs expedited processing, Food Stamps must be received by the seventh calendar day after the application date. (7-1-98)

07. Normal Processing. If processing under normal procedures, the Department must verify circumstances before determining eligibility. Changes and recertifications are processed using the standards for all other households. Resident clients have the same rights to adverse action notices, fair hearings and lost Food Stamps as all other households. (6-1-94)

08. Center Misusing Food Stamps. The Department must promptly notify FCS if it believes a center is misusing ~~*coupons*~~ Food Stamps. The Department must not take action before FCS takes action against the center. ~~*(7-1-98)*~~(10-1-06)T

794. TREATMENT CENTER RESPONSIBILITIES.
Treatment Center responsibilities are listed below: (6-1-94)

01. Appoint Authorized Representative. The publicly operated community mental health or private nonprofit organization running the center must designate an authorized representative. (6-1-94)

a. The authorized representative must be an employee, over age eighteen (18). (6-1-94)

b. The authorized representative applies for, obtains and uses the Food Stamps on behalf of a resident. (6-1-94)

c. The Food Stamps can be used to purchase meals served at the center. (6-1-94)

d. The authorized representative must be knowledgeable about the financial circumstances of the client. (6-1-94)

e. The authorized representative's designation must not interfere with the treatment and rehabilitation program of the client. (6-1-94)

02. Notify Department of Changes. The center must notify the Department of changes in household circumstances affecting eligibility or Food Stamp amount, including when a resident leaves the center. (6-1-94)

03. Return Food Stamps. (6-1-94)

a. The center must return all issue documents and Food Stamps, not given to a departing resident, to the Department. (6-1-94)

b. Food Stamps must be returned to the Department if the client left before the sixteenth of the month and the center was unable to give him the Food Stamps. (6-1-94)

c. Food Stamps must be returned to the Department if they were left over for a resident who left on or after the sixteenth of the month. (6-1-94)

04. Fraud or Misrepresentation. The center is responsible for misrepresentation or fraud in certification of resident clients. The center is liable for residents' overissuances, losses, or misuse of Food Stamps. (6-1-94)

05. Give Food Stamps to Departing Client. (6-1-94)

a. The center must give the departing client the ID card and any unredeemed Food Stamps. (6-1-94)

b. The center must give the client a full month's Food Stamps if they have been issued, but none have been spent on behalf of the client. (6-1-94)

c. The center must give the departing client one-half (1/2) of the monthly Food Stamps if the client leaves before the sixteenth of the month and a portion of the Food Stamps have been spent on behalf of the client. (6-1-94)

d. If the client leaves the center on or after the sixteenth, and Food Stamps were issued and used, the center is not required to give Food Stamps to the client. (6-1-94)

06. End Representation. The center must not be an authorized representative for clients who leave the center. (6-1-94)

07. Food Stamp Misuse. The center must be disqualified if it is administratively or judicially found the center misappropriated or used ~~*coupons*~~ Food Stamps for purchases not contributing to a certified client's meals. ~~*(6-1-94)*~~(10-1-06)T

08. FCS Disqualifies Center. If FCS disqualifies a center as a retailer, the Department must close residents' cases. Individual notice of adverse action is not required. (7-1-98)

795. RESIDENTS OF GROUP LIVING ARRANGEMENTS.
Disabled or blind residents of public or private non-profit group living arrangements, serving no more than sixteen (16) residents may get Food Stamps. Residents get Food Stamps under the same standards as other households. Group living arrangements rules are listed below: (6-1-94)

01. FCS Authorized Retailer or Department Certified. The center must be an FCS authorized retailer or be certified by the Department as a non-profit group living center. Center status must comply with Section 1616(e) of the Social Security Act or comparable standards of the Secretary of USDA. (7-1-98)

02. List of Residents. Each center must give the Field Office a list of current Food Stamp residents. The list must include a statement, signed by a center official, attesting the validity of the list. The Department must require the list on a periodic basis. The Department must conduct random on-site visits to assure the accuracy of the list. (6-1-94)

03. Application Option. Residents may apply on their own. Residents may apply as a group. Residents may apply through an authorized representative employed and designated by the center. Residents may apply through an authorized representative of the resident's choice. (6-1-94)

04. Residents Apply on Their Own Behalf. A person or a group of residents making up a household can apply on their own behalf. The center must determine the resident is physically and mentally capable of handling his own affairs. If the resident is eligible the center does not act as the authorized representative. The resident or group is responsible for reporting any changes affecting eligibility or benefit level. The resident is responsible for overissuances. (6-1-94)

05. Certification. Residents of a center applying through the center's authorized representative must be certified as a one (1) person household. Residents of a center applying on their own behalf must be certified according to household size. (6-1-94)

06. Benefit Level. Eligibility and benefit levels are based on the income and resources of the household. (6-1-94)

07. Exempt From Work Registration. Residents are exempt from work registration. (6-1-94)

08. Notices. Residents are entitled to notices of adverse action. If a group living arrangement center loses its authorization or certification notice is not required. (6-1-94)

09. Using Food Stamps. The Food Stamps may be used by the resident, a group of residents, or by the center to purchase food for the resident. The center may accept ~~*coupons*~~ Food Stamps as payment for meals. If residents purchase or prepare food for home consumption, the center must insure each resident's ~~*coupons*~~ Food Stamps are used for meals intended for that resident. ~~*(6-1-94)*~~(10-1-06)T

10. Penalties and Disqualifications. The center can be penalized or disqualified if Food Stamps are misappropriated or used for purchases not contributing to the household. The misuse may be determined administratively or judicially. The Department must promptly notify FCS if it believes a center is misusing Food Stamps. The Department must not take action before FCS makes a determination. If FCS disqualifies a center as a retailer, the Department must suspend the center's authorized representative status for the same period. If the center loses FCS authorization to accept and redeem Food Stamps or is no longer authorized by the Department, its residents are no longer eligible for Food Stamps. The residents are not entitled to notice of adverse action. (7-1-98)

11. Authorized Representative Liability. Authorized representatives assigned by a group living arrangement ~~*shall be*~~ are liable for an over issuance, if they give false information. ~~*(3-15-02)*~~(10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

876. PERSONNEL REQUIREMENTS.
The Department must provide the qualified employees needed to assure prompt action on applications and issuance of benefits. Department employees certifying households for Food Stamps must be hired under Idaho Personnel Commission standards. Only qualified Department employees can interview households and determine eligibility and benefit amount. Only authorized employees or contractors of the Department may have access to Food Stamp~~*s, Authorization to Participate (ATP)*~~ cards or other issuance documents. ~~*(6-1-94)*~~(10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

883. QUALITY CONTROL AND FOOD STAMP ELIGIBILITY.
State Quality Control (SQC) is the Department's case review system. SQC determines rates of correct Food Stamp issuances and Department and recipient caused errors. ~~QC~~ Quality control reviews open Food Stamp cases, denials and closures. The quality control review period extends from October 1st to September 30th of the next year. Households selected for quality control review by State Quality Control (SQC) and Federal Quality Control (FQC) must cooperate with both reviews. If a household refuses to cooperate in a SQC or FQC review, it is ineligible for Food Stamps as shown below: ~~(6-1-94)~~(10-1-06)T

01. Refusal to Cooperate with SQC or FQC. If a household refuses to cooperate in a SQC or FQC review, it is not eligible. The SQC analyst or FQC reviewer ~~will tell~~ must notifiy the appropriate Department Self Reliance Specialist (SRS) of the household's refusal to cooperate. ~~(6-1-94)~~(10-1-06)T

~~b~~a. The Department must send the household advance notice to end Food Stamps. The notice must list the reason for the proposed action ~~reason~~, the right to a hearing, the right to schedule a conference or to continue the SQC or FQC review. ~~(6-1-94)~~(10-1-06)T

~~a~~b. The Department will close the Food Stamp case. (6-1-94)

02. Food Stamp Eligibility During ~~QC~~ Quality Control Review Period, After Refusal to Cooperate. ~~The QC review period extends from October 1 to September 30.~~ The household is not eligible for Food Stamps during the ~~QC~~ Quality Control review period until it cooperates with the SQC or FQC review. ~~(6-1-94)~~(10-1-06)T

03. Food Stamps After Review Period, Refusal to Cooperate With SQC. ~~The QC review period extends from October 1 to September 30.~~ The household is not eligible for Food Stamps until ~~ninety-five (95)~~ one hundred thirteen (113) days after the end of the annual review period. After this time: ~~(6-1-94)~~(10-1-06)T

a. The household must reapply. (6-1-94)

b. The household must supply proof of all current eligibility information before certification. (6-1-94)

04. Food Stamps After Review Period, Refusal to Cooperate with FQC. ~~The QC review period extends from October 1 to September 30.~~ The household is not eligible for Food Stamps until seven (7) months after the end of the annual review period. After this time: ~~(6-1-94)~~(10-1-06)T

a. The household must reapply. (6-1-94)

b. The household must supply proof of all current eligibility information before certification. (6-1-94)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is March 1, 2006. This pending rule has been adopted by the agency and is now pending review by the 2007 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 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.

This rule change helps those Medicaid recipients who are also on Medicare by providing an increase in the basic allowance that will provide additional money for the Medicaid recipient to pay for out of pocket medical expenses under the new Medicare Prescription Drug Plan. Originally this rulemaking allowed for an increase of $20 by increasing the individual's basic allowance from $67 a month to $87 a month. This amount is being amended by changing the increase from $20 to $10. The basic allowance will be increased from $67 to $77. This amendment to the rule is being made based on a comment to the rule made by the Department and is a result of a compromise reached with stakeholders during the legislative session.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. 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 from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the January 4, 2006 Idaho Administrative Bulletin, Vol. 06-1, pages 85 through 87.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. There is no fiscal impact to the state general fund due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Peggy Cook at (208) 334-5969.

DATED this 27th day of January, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2006.

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 Sections 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than January 18, 2006.

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

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

Beginning January 1, 2006, Medicaid recipients who are also on Medicare will no longer have their prescriptions paid for by Idaho's Medicaid Program. They will be covered by the new Medicare Prescription Drug Plan. Under the new drug plan, Medicaid recipients on Medicare will have out of pocket costs of $1 or $3 for each prescription and may also have an additional cost for the monthly premium of their chosen drug plan. The increase in the basic allowance assists this population by providing additional money for the Medicaid recipient so it can be used on their increased out of pocket medical costs. The rule changes will increase the individual's basic allowance from $67 a month to $87 a month in the following living arrangements: Room and Board Home, Residential and Assisted Living Facilities (RALF), and Certified Family Homes (CFH).

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a) and (b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: This rulemaking is being promulgated for protection of the public health, safety and welfare; and also confers a benefit.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: NA - There is no fee attached to this rulemaking. The $1 to $3 out of pocket costs is for Medicare, not Medicaid.

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

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule confers a benefit to participants and no objections to the rule are expected.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Peggy Cook at (208) 334-5969.

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 January 25, 2006.

DATED this 15th day of November, 2005.

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) 334-6558 fax
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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

501. BASIC ALLOWANCE.
Each participant receives a basic allowance unless he lives in a nursing facility. The basic allowance for each living arrangement is listed in Subsections 501.01 through 501.05. The Semi-Independent Group Residential Facility, Room and Board, Residential and Assisted Living Facility and Certified Family Home basic allowances are those in effect January 1, 2001. They do not change with the annual cost-of-living increase in the federal SSI benefit amount. (5-3-03)

01. Single Participant. Through December 31, 2000, a participant is budgeted five hundred forty-five dollars ($545) monthly as a basic allowance when living in a situation described in Subsections 501.01.a. through 501.01.e. Beginning January 1, 2001, the basic allowance increase for a single participant is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. (3-30-01)

a. Living alone. (7-1-99)

b. Living with his ineligible spouse. (7-1-99)

c. Living with another participant who is not his spouse. (7-1-99)

d. Living in another's household. This includes a living arrangement where the participant purchases lodging (room) and meals (board) from his parent, child or sibling. (3-30-01)

e. Living with his TAFI child. (7-1-99)

02. Couple or Participant Living With Essential Person. Through December 31, 2000, a participant living with his participant spouse or his essential person is budgeted seven hundred sixty-eight dollars ($768) monthly as a basic allowance. Beginning January 1, 2001, the basic allowance increase for a couple is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a couple. The increase may be rounded up. (3-30-01)

03. SIGRIF. A participant living in a semi-independent group residential facility (SIGRIF) is budgeted three hundred forty-nine dollars ($349) monthly as a basic allowance. (7-1-99)

04. Room and Board Home. A participant living in a room and board home, as defined in Section 512, is budgeted ~~*sixty eighty*~~ seventy-seven dollars ($~~*68*~~77) monthly as a basic allowance. ~~*(3-15-02)(1-1-06)T*~~(3-1-06)T

05. Personal Care Supplement. A participant living in a Residential and Assisted Living Facility, or Certified Family Home with state plan personal care services, is budgeted five hundred and twenty dollars ($520) monthly as a Basic Allowance, if he does not have enough income to pay his provider for his rent, utilities and food. To receive a Personal Care Supplement, the participant's income after exclusions and disregards must be less than his Basic Allowance. Beginning January 1, 2003, the basic allowance increase is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. (5-3-03)

(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.*~~ Beginning January 1, 2006, a participant living in a room and board home is budgeted six hundred ninety-three dollars ($693). Beginning January 1, 2007, 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. ~~*(3-20-04)*~~(1-1-06)T

513. LICENSED RESIDENTIAL AND ASSISTED LIVING FACILITY AND CERTIFIED FAMILY HOME ALLOWANCES.
A participant living in a Residential and Assisted Living Facility (RALF), (~~*see*~~ in accordance with

IDAPA 16.03.22, "Rules Governing Licensed Residential and Assisted Living Facilities in Idaho") or Certified Family Home (CFH), (~~see~~ in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes") with State Plan Personal Care Services, is budgeted a basic allowance of ~~sixty~~ ~~eighty~~ seventy-seven dollars ($~~68~~77) monthly. A participant is also budgeted a monthly allowance for care based on his level of care. If the participant gets a lower level of RALF or CFH care than his assessed level, his allowance is for the lower level of care. These allowances are used to determine eligibility for Medicaid. ~~The participant is not entitled to AABD cash assistance, unless he~~ These allowances are only used for AABD cash when the participant is entitled to the ~~Personal Care Supplement in Subsection 512.05 of these rules~~ DD Waiver in accordance with Section 789, "Developmentally Disabled (DD) Waiver," of this rule. If the participant does not require the RALF or CFH level of care, his eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. ~~A participant with Home and Community-Based Services for the aged and disabled (HCBS-A&D) is not entitled to cash assistance.~~ ~~(5-3-03)(1-1-06)T~~(3-1-06)T

01. Care Levels and Monthly Allowances. ~~Through December 31, 2000~~ Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513. ~~Beginning January 1, 2001, through December 31, 2001, the RALF and CFH care allowances and the basic allowance increase by 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, 200~~2~~7, the RALF and CFH allowances increase by the full dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person.

TABLE 513 - CARE LEVELS AND ALLOWANCES AS OF 1~~2-3~~1-0~~0~~6		
	Level Of Care	Monthly Allowance
a.	Level I	~~Seven~~ Eight hundred and ~~seventy four~~ thirty-five dollars ($~~774~~835)
b.	Level II	~~Eight~~ Nine hundred and ~~forty one~~ two dollars ($~~841~~902)
c.	Level III	Nine hundred and sixty-nine dollars ($9~~0~~69)

~~(3-15-02)~~(1-1-06)T

02. CFH Operated by Relative. A participant living in a Certified Family Home (CFH) operated by his parent, child or sibling is not entitled to the CFH allowances. He may receive the allowance for a person living with a relative. A relative for this purpose is the participant's parent, child, sibling, aunt, uncle, cousin, niece, nephew, grandparent or grandchild by birth, marriage, or adoption. (3-15-02)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0602

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective dates of the amendments to the temporary rules are January 1, 2006, February 8, 2006 and July 1, 2006. This pending rule has been adopted by the agency and is now pending review by the 2007 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 56-202(b), Idaho Code, and the federal Deficit Reduction Act (DRA) of 2005.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the 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 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 from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the July 5, 2006 Idaho Administrative Bulletin, Vol. 06-7, pages 45 through 58.

The amendments to these rules are the result of comments received from the Centers for Medicare and Medicaid Services on the DRA of 2005, and comments received during the comment period. The following are specific changes made to the temporary and proposed rules:

1) Section 105 - amended U.S. citizenship and identity documentation requirements for what can be accepted as proof for these requirements.
2) Section 238 - amended the home equity exclusion amount for a participant in long-term care from $500,000 to $750,000.
3) Section 247 - amended to clarify that one (1) year is twelve (12) consecutive months.
4) Section 831 - amended to clarify that the asset transfer amount was the outstanding balance due on the date of the Medicaid application.

5) Section 835 - amended to clarify that restricted coverage continues until the fair market value at the time of the transfer for all assets is received.

6) Section 836 - added to clarify requirements regarding multiple penalty periods.

7) Section 838 - amended to clarify the conditions under which an annuity is considered to be an asset transfer.

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

There is no anticipated fiscal impact to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Peggy Cook at (208) 334-5969.

DATED this 28th day of September, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: There are three effective dates for this temporary rule. The dates are January 1, 2006, February 8, 2006, and July 1, 2006.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-202(b), Idaho Code, and the federal Deficit Reduction Act (DRA) of 2005.

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

DATE: Thursday, July 13, 2006
TIME: 10:00 a.m.
PLACE: Department of Health and Welfare
Pete T. Cenarussa Bldg., 6th Floor Conference Room
450 W. State Street, Boise, 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 the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The "Deficit Reduction Act (DRA) of 2005" became law to help reduce and slow the rising

costs for Medicaid. The DRA addresses several different issues with requirements that have several effective dates.

These temporary rules are being adopted to align the state rules with the DRA. The DRA requires applicants to disclose all interests in annuities and other financial instruments, extends the period of time that asset transfers must be reviewed and can be penalized, and requires the applicant to name the state as a remaining beneficiary. These amendments to the rules separate annuities and life estates into their own sections of rules, and align the trust rules with the federal requirements under the DRA. The rules that apply to trusts, life estates, and annuities also apply to estate recovery rules. These rules are being amended to help prevent the sheltering of assets. These rules apply the new requirements for documentation and proof of identity and citizenship, as established in the DRA to help in the determination of eligibility.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b), the Governor has found that temporary adoption of the rule is appropriate for the following reasons: The Deficit Reduction Act (DRA) of 2005 is federal law governing this rulemaking and requires effective dates as noted above. Some changes have been made to clarify the language and intent for the existing rule without changing substance or adding content in the sections that are open for the DRA Act.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. There is no anticipated fiscal impact increase to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted with parties that had expressed concerns with a previous rulemaking on these issues as well as the DRA. The Department held informal negotiations with the Trust and Estate Professionals of Idaho on this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Peggy Cook at (208) 334-5969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 26, 2006.

DATED this 2nd day of June, 2006.

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) 334-6558 fax
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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

102. -- 10~~4~~3. (RESERVED).

10~~5~~4. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.
The applicant must provide his social security number (SSN) or proof he has applied for an 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. 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. (3-20-04)

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. (3-20-04)

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: (3-20-04)

a. Is a member of a recognized religious sect or division of the sect; and (3-20-04)

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. (3-20-04)

03. SSN Requirement Waived. An applicant may have the SSN requirement waived when he is: (3-20-04)

a. Only eligible for emergency medical services as described in Section 801 of these rules; or (3-20-04)

b. A waived newborn child as described in Section 800 of these rules. (3-20-04)

105. ~~*IDENTITY AND PROOF OF*~~ U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.
To be eligible *for Medicaid*, an individual must provide documentation of ~~*identity and either*~~ U.S. citizenship ~~*or qualified non-citizenship,*~~ *and identity* unless he has otherwise met the requirements under Subsection 105.0~~4~~*8* of this rule. ~~*The following are acceptable forms of documentation:*~~ *The individual must provide the Department with the most reliable document that is available. Documents must be originals or copies certified by the issuing agency. Copies of originals or notarized copies cannot be accepted. The Department will accept original documents in person, by mail, or through a guardian or authorized representative.* ~~*(7-1-06)T*~~*(7-1-06)T*

01. Documents Accepted as *Primary Level* Proof of Both ~~Identity and~~ U.S. Citizenship *and Identity*. The following documents ~~*may be*~~ *are* accepted as *the primary level of* proof of both U.S. citizenship and identity: ~~*(7-1-06)T*~~*(7-1-06)T*

a. A U.S. passport; (7-1-06)T

b. A Certificate of Naturalization, DHS Forms N-550 or N-570; *or* ~~*(7-1-06)T*~~*(7-1-06)T*

c. A Certificate of U.S. Citizenship, DHS Forms N-560 or N-561~~.~~. ~~*or*~~ ~~*(7-1-06)T*~~*(7-1-06)T*

~~**d.** *A driver's license if the state issuing the license requires proof of citizenship before the license is issued.* *(7-1-06)T*~~

02. Documents Accepted as *Secondary Level* Proof of U.S. Citizenship but Not Identity. The following documents ~~*may be*~~ *are* accepted as proof of U.S. citizenship ~~*only*~~ *if the proof in Subsection 105.01 is not available*. ~~*They*~~ *These documents* are not proof of identity and must be used in combination with a least one (1) document listed in Subsection*s* 105.0~~*3*~~*5 or 105.06* of this rule to establish both citizenship and identity. ~~*(7-1-06)T*~~*(7-1-06)T*

a. A U.S. birth certificate~~;~~ *that shows the individual was born in one (1) of the following:* ~~*(7-1-06)T*~~*(7-1-06)T*

i. United States fifty (50) states; *(7-1-06)T*

ii. District of Columbia; *(7-1-06)T*

iii. Puerto Rico, on or after January 13, 1941; *(7-1-06)T*

iv. Guam, on or after April 10, 1899; *(7-1-06)T*

v. U.S. Virgin Islands, on or after January 17, 1917, *(7-1-06)T*

vi. America Samoa; *(7-1-06)T*

vii. Swain's Island; or *(7-1-06)T*

viii. Northern Mariana Islands, after November 4, 1986; *(7-1-06)T*

b. *A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545;* *(7-1-06)T*

~~**b**~~***c.*** A report of birth abroad of a U.S. Citizen, Form FS-~~*545 or DS-1350*~~*240*; ~~*(7-1-06)T*~~*(7-1-06)T*

~~**e**~~***d.*** A U.S. Citizen I.D. card, DHS Form I-197; (7-1-06)T

~~d. A hospital record of birth issued at the time of birth in one (1) of the fifty (50) states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands. If the person was born to foreign diplomats residing in one (1) of the preceding jurisdictions of the U.S., he is not a citizen of the United States;~~ ~~(7-1-06)T~~

~~e. A religious record of birth recorded in the United States or its territories within three (3) months of birth which indicates a U.S. place of birth. This document must show either the date of birth or the individual's age at the time the record was made;~~ ~~(7-1-06)T~~

~~f~~e. A Northern Mariana Identification Card~~ issued by the Immigration and Naturalization Service (INS) to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 3, 1986~~, Form I-873; ~~(7-1-06)T~~(7-1-06)T

~~g~~f. An American Indian Card issued by the Department of Homeland Security *with the classification code "KIC," Form I-873*; ~~(7-1-06)T~~(7-1-06)T

~~h. Information from a primary source such as the State Data Exchange (SDX) or birth confirmations from Vital Statistics; or~~ ~~(7-1-06)T~~

~~i. An affidavit made by a blood relative of the individual and who has personal knowledge of the events establishing the individual's claim of citizenship. For example, the date and place of the individual's birth in the United States.~~ ~~(7-1-06)T~~

g. *A final adoption decree showing the child's name and U.S. place of birth;* *(7-1-06)T*

h. *Evidence of U.S. Civil Service employment before June 1, 1976; or* *(7-1-06)T*

i. *An official U.S. Military record showing a U.S. place of birth.* *(7-1-06)T*

03. Documents Accepted as Third Level Proof of U.S. Citizenship but Not Identity. *The following documents are accepted as proof of U.S. citizenship if a primary or secondary level of proof is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 105.05 or 105.06 of this rule to establish both citizenship and identity.* *(7-1-06)T*

a. *A written hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date that indicates a U.S. place of birth; or* *(7-1-06)T*

b. *Life, health, or other insurance record that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth.* *(7-1-06)T*

04. Documents Accepted as Fourth Level Proof of U.S. Citizenship but Not Identity.

The following documents are accepted as proof of U.S. citizenship only if documents in Subsections 105.01 through 105.03 of this rule do not exist and cannot be obtained for a person who claims U.S.citizenship. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 105.05 or 105.06 of this rule to establish both citizenship and identity. *(7-1-06)T*

a. *Federal or state census record that shows the individual has U.S. citizenship or a U.S. place of birth;* *(7-1-06)T*

b. *One (1) of the following documents that shows a U.S. place of birth and was created at least five (5) years before the application for Medicaid;* *(7-1-06)T*

i. *Seneca Indian tribal census record;* *(7-1-06)T*

ii. *Bureau of Indian Affairs tribal census records of the Navajo Indians;* *(7-1-06)T*

iii. *U.S. State Vital Statistics official notification of birth registration;* *(7-1-06)T*

iv. *An amended U.S. public birth record that is amended more than five (5) years after the person's birth;* *(7-1-06)T*

v. *Statement signed by the physician or midwife who was in attendance at the time of birth;* *(7-1-06)T*

vi. *Medical (clinic, doctor, or hospital) record;* *(7-1-06)T*

vii. *Institutional admission papers from a nursing facility, skilled care facility or other institution; or* *(7-1-06)T*

c. *A written declaration, signed and dated, which states, "I declare under penalty of perjury that the foregoing is true and correct." A declaration is accepted if no other documentation is available and complies with the following:* *(7-1-06)T*

i. *Declarations must be made by two (2) persons who have personal knowledge of the events establishing the individual's claim of U.S. citizenship;* *(7-1-06)T*

ii. *One (1) of the persons making a declaration cannot be related to the individual claiming U.S. citizenship;* *(7-1-06)T*

iii. *Neither of the two (2) persons making the declaration can be an applicant or recipient of Medicaid;* *(7-1-06)T*

iv. *The persons making the declaration must provide proof of their own U.S. citizenship and identity; and* *(7-1-06)T*

v. *The persons making the declaration must provide an explanation as to why documentation for the individual does not exist or cannot be obtained.* *(7-1-06)T*

vi. A declaration must be obtained from the individual applying for Medicaid, a guardian, or representative that explains why the documentation does not exist or cannot be obtained. *(7-1-06)T*

0~~3~~5. Documents Accepted for Proof of Identity but Not Citizenship. The following documents ~~*may be*~~ *are* accepted as proof of identity. They are not proof of citizenship and must be used in combination with at least one (1) document listed in Subsection 105.0~~2~~*21 through 105.04* of this rule to establish both citizenship and identity. ~~*(7-1-06)T*~~*(7-1-06)T*

a. A ~~*current*~~ state-*issued* driver's license bearing the individual's picture *or other identifying information such as name, age, gender, race, height, weight, or eye color*; ~~*(7-1-06)T*~~*(7-1-06)T*

b. A *federal,* state*, or local government*-issued identity card ~~*issued to a non-driver bearing the individual's picture for which the state required proof of identity as a condition of issuing the identity document; or*~~ *with the same identifying information that is included on driver's licenses as described in Subsection 105.05.a of this rule;* ~~*(7-1-06)T*~~*(7-1-06)T*

c. ~~*Any other document the state finds that establishes the true identity of the individual.*~~ *School identification card with a photograph of the individual;* ~~*(7-1-06)T*~~*(7-1-06)T*

d. *U.S. Military card or draft record;* *(7-1-06)T*

e. *Military dependent's identification card;* *(7-1-06)T*

f. *U. S. Coast Guard Merchant Mariner card;* *(7-1-06)T*

g. *Certificate of Degree of Indian blood; or* *(7-1-06)T*

h. *Native American Indian or Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual.* *(7-1-06)T*

06. Identity Rules for Children*. The following documentation of identity for children under sixteen (16) may be used:* *(7-1-06)T*

a. *School records may be used to establish identity. Such records also include nursery or daycare records.* *(7-1-06)T*

b. *A written declaration, signed and dated, which states, "I declare under penalty of perjury that the foregoing is true and correct," if documents listed in Subsection 105.02 of this rule are not available. A declaration may be used if it meets the following conditions:* *(7-1-06)T*

i. It states the date and place of the child's birth; and *(7-1-06)T*

ii. It is signed by a parent or guardian. *(7-1-06)T*

c. *A declaration cannot be used for identity if a declaration for citizenship documentation was provided for the child.* *(7-1-06)T*

07. Eligibility for Applicants and Medicaid Participants Who Do Not Provide Citizenship and Identity Documentation. *(7-1-06)T*

a. *Eligibility will be denied to any applicant who does not provide proof of citizenship and identity documentation;* *(7-1-06)T*

b. *Any Medicaid participant, who does not provide proof of citizenship and identity documentation at a scheduled renewal and who is making a good faith effort to obtain documentation, will not be terminated from Medicaid for lack of documentation unless the participant:* *(7-1-06)T*

i. Does not meet other eligibility criteria required in this chapter of rules; or *(7-1-06)T*

ii. Refuses to obtain the documentation. *(7-1-06)T*

04~~8~~. Individuals Considered as Meeting the U.S. Citizenship and Identity Documentation Requirements. The following individuals are considered to have met the U.S. citizenship and identity documentation requirements, *regardless of whether documentation required in Subsections 105.01 through 105.07 of this rule is provided*: ~~*(7-1-06)T*~~*(7-1-06)T*

~~**a.** *Children receiving Title IV-E foster care assistance;* *(7-1-06)T*~~

~~**b**~~***a.*** SSI ~~*or RSDI*~~ recipients; and ~~*(7-1-06)T*~~*(7-1-06)T*

~~**c**~~***b.*** *Individuals determined by the SSA to be entitled to or are receiving* Medicare ~~*recipients*~~. ~~*(7-1-06)T*~~*(7-1-06)T*

09. Title IV-E Foster Care Child*. The Department will not deny or delay Medicaid for a child receiving Title IV-E Foster Care assistance pending citizenship and identity documentation.* *(7-1-06)T*

10. Assistance in Obtaining Documentation*. The Department will assist individuals who are mentally or physically incapacitated and who lack a representative to assist them in obtaining such documentation.* *(7-1-06)T*

11. Provide Documentation of Citizenship and Identity One Time*. When an individual has provided citizenship and identity documents, changes in eligibility will not require an individual to provide such documentation again unless later verification of the documents provided raises a question of the individual's citizenship or identity.* *(7-1-06)T*

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~~5 of ~~*this*~~ these rules. An individual must also provide proof of identity as provided in Section 105 of these rules. ~~*(3-20-04)*~~(7-1-06)T

01. U.S. Citizen. A U.S. Citizen~~; or~~. ~~(3-20-04)~~(7-1-06)T

02. U.S. National, National of American Samoa or Swain's Island. A U. S. National, National of American Samoa or Swain's Island~~; or~~. ~~(3-20-04)~~(7-1-06)T

03. Child Born Outside the U.S. A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: (7-1-06)T

a. At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; (7-1-06)T

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen; (7-1-06)T

c. The child is under eighteen (18) years of age; (7-1-06)T

d. The child is a lawful permanent resident; and (7-1-06)T

e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent.(7-1-06)T

0~~3~~4. 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~~. ~~(3-20-04)~~(7-1-06)T

0~~4~~5. 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~~. ~~(3-20-04)~~(7-1-06)T

0~~5~~6. 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~~ and remained continuously present in the U.S. until they became a qualified alien. ~~(3-20-04)~~(7-1-06)T

0~~6~~7. Non-Citizen Entering on or After August 22, 1996. A non-citizen who entered on or after August 22, 1996, and; ~~(3-20-04)~~(7-1-06)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~~ ~~(3-20-04)~~(7-1-06)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~~ ~~(3-20-04)~~(7-1-06)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~~ ~~(3-20-04)~~(7-1-06)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 (3-20-04)

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~~. ~~(3-20-04)~~(7-1-06)T

0~~7~~8. 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~~ held a qualified non-citizen status for at least five (5) years~~; or~~. ~~(3-20-04)~~(7-1-06)T

0~~8~~9. American Indian Born in Canada. An American Indian born in Canada under 8 U.S.C. 1359~~; or~~. ~~(3-20-04)~~(7-1-06)T

~~09~~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~~. ~~(3-20-04)~~(7-1-06)T

1~~0~~1. 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~~. ~~(3-20-04)~~(7-1-06)T

1~~1~~2. 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: (3-20-04)

a. Is under the age of eighteen (18) years; or (3-20-04)

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 (3-20-04)

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 (3-20-04)

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons~~; or~~. ~~(3-20-04)~~(7-1-06)T

1~~2~~3. 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 (3-20-04)

1~~3~~4. Permanent Resident Receiving AABD Cash On August 22, 1996. A permanent resident receiving AABD cash on August 22, 1996. (3-20-04)

1~~4~~5. 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~~3~~4 of this rule, may be eligible for emergency medical services if they meet all other conditions of eligibility. ~~(3-20-04)~~(7-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

238. HOME ~~EXCLUDED~~ AS RESOURCE.
~~The value of a participant's home is an excluded resource.~~ An ~~participant's~~ individual's home is property he owns, and ~~serving~~ serves as his principal place of residence. His principal place of residence is the place he considers his principal home. If the ~~participant~~ individual is absent from his home, it is still his principal place of residence if he intends to return. ~~(7-1-99)~~(1-1-06)T

01. AABD Cash, and Medicaid With the Exception of Long-Term Care. For AABD Cash and Medicaid with the exception of long-term care, the value of an individual's home is an excluded resource. (1-1-06)T

02. Long-Term Care Services. For long-term care services, when the value of a participant's equity in the home is ~~five~~ *seven* hundred *fifty* thousand dollars ($~~50~~750,000) or less, the home is excluded as a resource. When the equity value exceeds ~~five~~ *seven* hundred *fifty* thousand dollars ($~~50~~750,000), the individual is ineligible for long-term care services. The equity value, regardless of the amount, is an excluded resource when one (1) of the following applies: ~~(1-1-06)T~~(1-1-06)T

a. The spouse of the individual lives in the home; or (1-1-06)T

b. The individual's child, who is under age twenty-one (21), or is blind, or meets the disability requirements for AABD cash, lives in the home. (1-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

247. LIFE ESTATE INTEREST IN ANOTHER'S HOME.
The purchase of a life estate interest in another individual's home is a resource unless the purchaser resides in the home for a period of at least ~~one (1) year~~ *twelve (12) consecutive months* after the date of purchase. ~~(2-8-06)T~~*(2-8-06)T*

24~~7~~8. -- 254. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

273. -- 27~~6~~5. (RESERVED).

27~~7~~6. 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. (3-20-04)

277. FEES PAID TO A CONTINUING CARE RETIREMENT COMMUNITY (CCRC) OR LIFE CARE COMMUNITY.
An entrance fee to a CCRC or a life care community is a resource if the participant or applicant for long-term care has discretion to spend the fee or if the fee may be used to pay for care in a contingency. A CCRC or life care community is a type of long-term care facility that offers varying levels of care and in which a resident contracts with the facility to obtain care that is intended to endure for the remainder of the resident's life in exchange for valuable consideration. (2-8-06)T

(BREAK IN CONTINUITY OF SECTIONS)

285. AABD PERIOD OF INELIGIBILITY FOR RESOURCE TRANSFERS.
The resource transfer period of ineligibility is a period of AABD ineligibility for up to ~~*thirty*~~ sixty (~~*3*~~60) months. The period of ineligibility begins the first day of the month after the transfer month. The participant must be notified, in writing, at least ten (10) days before a resource transfer period of ineligibility is imposed. ~~*(3-15-02)*~~(2-8-06)T

286. RESOURCE TRANSFER LOOK-BACK PERIOD.
The resource transfer ~~*period of ineligibility*~~ penalty applies to any transfer~~*s in a thirty-six (36) month look-back period.*~~ for less than fair market value made during a period preceding a request for cash assistance. The look-back period is determined as follows: ~~*(3-15-02)*~~(2-8-06)T

01. ~~***Look-Back for an Applicant****. The look-back period begins thirty-six (36) months before the application date.*~~ **Transfers Prior to February 8, 2006**. For any resource transferred prior to February 8, 2006, the look-back period is thirty-six (36) months. The look-back period is counted from the month prior to the month the application was submitted. ~~*(3-15-02)*~~(2-8-06)T

02. ~~***Look-Back for a Participant****. The look-back date is the date the participant transferred the resource. A transfer of resources at any time after the look-back start date may result in a period of ineligibility.*~~ **Transfers On or After February 8, 2006**. Any resource transferred on or after February 8, 2006, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for cash, or the date of the transfer, whichever is later in time. ~~*(3-15-02)*~~(2-8-06)T

(BREAK IN CONTINUITY OF SECTIONS)

288. LENGTH OF PERIOD OF INELIGIBILITY.
The period of ineligibility begins with the month after the month the transfer took place. The period of ineligibility continues whether or not the participant receives AABD. Ineligibility continues until all the resources are returned to the participant or spouse, adequate consideration

for all the resources is received, ~~thirty-~~sixty (~~3~~60) months passes, or the penalty period ~~of ineligibility~~ ends. ~~(3-15-02)~~(2-8-06)T

(BREAK IN CONTINUITY OF SECTIONS)

744. INCOME COUNTED FIRST FOR CSRA REVISION.
Income is determined prior to determining resources. If the couple's income is more than the minimum CSA, the CSRA cannot be increased. If the community spouse has less income than the minimum CSA, the CSRA ~~may~~ must be increased as provided in Section 745. Couple income is the community spouse's gross income plus the long-term care spouse's income. The long-term care spouse's income is his gross income less the AABD cash income exclusions and his patient liability income deductions, but not the CSA deduction. ~~(7-1-99)~~(2-8-06)T

745. UPWARD REVISION OF CSRA.
If the community spouse's income, including income from his CSA and income-producing resources in his CSRA, is less than the minimum CSA, the CSRA ~~may~~ must be increased. The CSRA is increased by enough resources, transferred from the long-term care spouse, to raise the community spouse's income to the minimum CSA. Resources included in the transfer are presumed to produce income of five percent (5%) yearly, whether or not the resources produce income, or produce five percent (5%). If the community spouse shows he is making reasonable use of his income and resources, to generate income, the Department may waive the five percent (5%) yearly income requirement. Actual income produced by the resources transferred to the community spouse is used to compute the CSA. If the transferred resources produce more than five percent (5%) yearly income, the actual income produced is used to determine the additional resources that can be transferred to the community spouse in the CSRA. The long-term care spouse must transfer the resources to the community spouse, or the CSRA is not revised.
~~(7-1-99)~~(2-8-06)T

(BREAK IN CONTINUITY OF SECTIONS)

831. ASSET TRANSFER RESULTING IN PENALTY.
Starting August 11, 1993, the participant is subject to a penalty if he transfers his income or resources for less than fair market value. The asset transfer penalty applies to Medicaid services received October 1, 1993 and later. Excluded resources, other than the home and associated property, are not subject to the asset transfer penalty. Asset transfers subject to penalty under these rules may be voided and set aside by court action as provided in Section 56-218, Idaho Code. The asset transfer penalty applies to a Medicaid participant in long-term care or HCBS. A participant in long-term care is a patient in a nursing facility or a patient in a medical institution, requiring and receiving the level of care provided in a nursing facility. ~~(5-3-03)~~(2-8-06)T

01. Rebuttable Presumption. Unless a transfer meets the requirements of Section 841 of these rules, it is presumed that the transfer was made for the purpose of qualifying for Medicaid. The asset transfer penalty is applied unless the participant shows that the asset transfer

would not have affected his eligibility for Medicaid or the transfer was made for another purpose than qualifying for Medicaid. (4-11-06)

02. Contract for Services Provided by a Relative. A contract for personal services to be furnished to the participant by a relative is presumed to be made for the purpose of qualifying for Medicaid. The asset transfer penalty applies unless the participant shows that: (3-15-02)

a. A written contract for personal services was signed before services were delivered. The contract must require that payment be made after services are rendered. The contract must be dated and the signatures notarized. Either party must be able to terminate the contract; and (3-15-02)

b. The contract must be signed by the participant or a legally authorized representative through a power of attorney, legal guardianship or conservatorship. A representative who signs the contract must not be the provider of the personal care services under the contract; and (3-15-02)

c. Compensation for services rendered must be comparable to rates paid in the open market. (3-15-02)

03. Transfer of Income or Resources. Transfer of income or resources includes reducing or eliminating the participant's ownership or control of the asset. (4-5-00)

04. Transfer of Income or Resources by a Spouse. A transfer by the participant's spouse of either spouse's income or resources, before eligibility is established, subjects the participant to the asset transfer penalty. After the participant's eligibility is established, a transfer by the spouse of the spouse's own income or resources does not subject the participant to the asset transfer penalty. (4-5-00)

05. Transfer of Certain Notes and Loans. Funds used to purchase a promissory note, loan, or mortgage are considered a transferred asset which subjects the participant to a period of ineligibility~~.~~. *The amount of the asset transfer of such note, loan, or mortgage is the outstanding balance due on the date of the Medicaid application,* unless the note, loan, or mortgage *meets the following*: ~~*(2-8-06)T*~~(2-8-06)T

a. Has a repayment term that is actuarially sound; (2-8-06)T

b. Provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments ~~*made*~~; and ~~*(2-8-06)T*~~(2-8-06)T

c. Prohibits the cancellation of the balance upon the death of the lender. (2-8-06)T

(BREAK IN CONTINUITY OF SECTIONS)

833. ASSET TRANSFER LOOK-BACK PERIOD.

The asset transfer penalty applies to any transfer~~s in a thirty-six (36) month look-back~~ for less than fair market value made during a period preceding or following a request for long-term care services. The look-back period is ~~sixty (60) months for transfers to or from a trust.~~ determined as follows: ~~(7-1-99)~~(2-8-06)T

01. ~~**Look-Back for a Person Entitled to Medicaid**. *The look-back period begins the month long-term care or HCBS starts for a person entitled to Medicaid. A person "entitled to Medicaid" is receiving or applying for Medicaid when long-term care or HCBS starts. The person would be eligible for the month of application or any of the three (3) calendar months before it, if not for the asset transfer penalty.*~~ **Transfers Prior to February 8, 2006**. For any asset transferred prior to February 8, 2006, the look-back period is thirty-six (36) months, unless the transfer is to or from a trust. If the transfer is to or from a trust, the look-back period is sixty (60) months. If the person is entitled to Medicaid or HCBS services, the look-back period is counted from the month long-term care or HCBS services began, or would have begun, were it not for a penalty. If the person is not entitled to Medicaid, the look-back period is counted from the month prior to the month the application was submitted. ~~(7-1-99)~~(2-8-06)T

02. ~~**Look-Back for a Person Not Entitled to Medicaid**. *The look-back period begins the month before the application month for a person not entitled to Medicaid when long-term care starts.*~~ **Transfers On or After February 8, 2006**. Any asset transferred on or after February 8, 2006, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for long-term care or HCBS services or the date of the transfer, whichever is later in time. ~~(7-1-99)~~(2-8-06)T

834. PERIOD OF RESTRICTED COVERAGE FOR ASSET TRANSFERS.
The period of restricted coverage is the number of months computed by dividing the ~~*unpaid asset*~~ uncompensated value of the transferred asset by the statewide average cost of nursing facility services to ~~*a*~~ private patients~~ *of nursing facility services or HCBS*~~. The cost is computed for the time of the participant's most recent request for Medicaid. If the spouse becomes eligible for long-term care Medicaid, the rest of the period of restricted coverage is divided between the participant and spouse. ~~(7-1-99)~~(2-8-06)T

835. ~~*CALCULATING*~~ APPLYING THE PENALTY PERIOD OF RESTRICTED COVERAGE.
~~*If the amount transferred is less than the cost of one (1) month's care, there is no penalty. The penalty period begins running the month the transfer took place. The month the transfer took place is counted as one (1) of the penalty months.*~~ Restricted coverage continues until the participant or spouse ~~*gets*~~ recovers all the assets, ~~*back, gets adequate consideration*~~ receives fair market value *at the time of the transfer* for all of the assets, or the period of restricted coverage ends. The penalty continues whether or not the participant is in long-term care. The penalty period for asset transfers is applied as follows: ~~(7-1-99)(2-8-06)T~~(2-8-06)T

01. ~~**Single**~~ **Penalty Period for Transfer Prior to February 8, 2006**. ~~*A period of restricted coverage ends the last day of the last full month of the penalty period.*~~ For assets transferred prior to February 8, 2006, there is no penalty if the amount transferred is less than the cost of one (1) month's care. The penalty period begins running the month the transfer took place. The month the transfer took place is counted as one (1) of the penalty months. A penalty period is

computed for each transfer. A penalty period must expire before the next begins. Each partial month before the end of consecutive penalty periods is a penalty month. A partial month at the end of ~~a single~~ consecutive penalty periods is dropped. ~~(7-1-99)~~(2-8-06)T

02. ~~Consecutive~~ Penalty Period~~s~~ for Transfers On or After February 8, 2006. ~~*Each partial month before the end of consecutive penalty periods is a penalty month. A partial month at the end of consecutive penalty periods is dropped.*~~ For assets transferred on or after February 8, 2006, the penalty period begins running the first day of the month after the month the transfer took place, or the date the individual would have been eligible for long-term care services, if not for the transfer, whichever date is later in time. The value of all asset transfers made during the look-back period is accumulated for the purpose of calculating the penalty. If an additional transfer is discovered after the penalty has been served, a new penalty period begins the month following timely notice of closure of benefits. When a penalty period ends after the first day of the month, eligibility for long-term care services begins the day after the penalty period ends. ~~(7-1-99)~~(2-8-06)T

836. ~~(RESERVED)~~ *MULTIPLE PENALTY PERIODS APPLIED CONSECUTIVELY*.
A penalty period is computed for each transfer. One (1) penalty period must expire before the next begins. ~~(7-1-99)~~*(2-8-06)T*

837. LIFE ESTATE~~*S AND ANNUITIES*~~ AS ASSET TRANSFER~~*S*~~.
~~*Conditions for determining if*~~ When a life estate in real property is retained by an individual, and a remainder interest in the property is ~~*an asset*~~ transferred during the look-back period for less than the fair market value ~~*are listed in Subsection 837.01 of this rule. The purchase of an annuity is an asset transfer that is presumed to be made for the purpose of qualifying for Medicaid. The asset transfer penalty applies unless the participant shows the purchase of the annuity would not have affected his eligibility for Medicaid or, the payment from the annuity is not greater than necessary to meet the reasonable and ordinary monthly needs of the beneficiary. For the purposes of Section 837, the reasonable and ordinary monthly needs are those defined by the maximum community spouse allowance at Section 725 of these rules. The participant must also show that the annuity meets the conditions in Subsections 837.03 and 837.04 of this rule*~~ of the remainder interest transferred, the value of the uncompensated remainder is subject to the asset transfer penalty as described in Sections 831 through 835 of these rules. ~~*(5-3-03)*~~

~~***01. Life Estate**. A life estate worth less than the value of the transferred real property is subject to the asset transfer penalty.*~~ To compute the value of the life estate remainder, multiply the fair market value of the real property at the time of transfer by the remainder factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.~~*01*~~ - LIFE ESTATE REMAINDER TABLE

Age	Life Estate Remainder	Age	Life Estate Remainder	Age	Life Estate Remainder	Age	Life Estate Remainder
0	.02812	1	.01012	2	.00983	3	.00922
4	.01019	5	.01062	6	.01116	7	.01178
8	.01252	9	.01337	10	.01435	11	.01547

TABLE 837~~.01~~ - LIFE ESTATE REMAINDER TABLE							
Age	Life Estate Remainder	Age	Life Estate Remainder	Age	Life Estate Remainder	Age	Life Estate Remainder
12	.01671	13	.01802	14	.01934	15	.02063
16	.02185	17	.02300	18	.02410	19	.02520
20	.02635	21	.02755	22	.02880	23	.03014
24	.03159	25	.03322	26	.03505	27	.03710
28	.03938	29	.04187	30	.04457	31	.04746
32	.05.058	33	.05.392	34	.05.750	35	.06132
36	.06540	37	.06974	38	.07433	39	.07917
40	.08429	41	.08970	42	.09543	43	.10145
44	.10779	45	.11442	46	.12137	47	.12863
48	.13626	49	.14422	50	.15257	51	.16126
52	.17031	53	.17972	54	.18946	55	.19954
56	.20994	57	.22069	58	.23178	59	.24325
60	.25509	61	.26733	62	.27998	63	.29304
64	.30648	65	.32030	66	.33449	67	.34902
68	.36390	69	.37914	70	.39478	71	.41086
72	.42739	73	.44429	74	.46138	75	.47851
76	.49559	77	.51258	78	.52951	79	.54643
80	.56341	81	.58033	82	.59705	83	.61358
84	.63002	85	.64641	86	.66236	87	.67738
88	.69141	89	.70474	90	.71779	91	.73045
92	.74229	93	.75308	94	.76272	95	.77113
96	.77819	97	.78450	98	.79000	99	.79514
100	.80025	101	.80468	102	.80946	103	.81563
104	.82144	105	.83038	106	.84512	107	.86591
108	.89932	109	.95455				

~~(3-15-02)~~(2-8-06)T

838. ~~(RESERVED)~~ ANNUITY AS ASSET TRANSFER.
Except as provided in this rule, when assets are used to purchase an annuity during the look-back period, it is an asset transfer presumed to be made for the purpose of qualifying for Medicaid. To rebut this presumption, the participant must provide proof that clearly establishes the annuity was not purchased to make the participant eligible for Medicaid or avoid recovery *from the estate following death. In addition, the participant must show the annuity will be paid out in the participant's expected life, is irrevocable, earns interest at a reasonable rate of return, and names the state as the remainder beneficiary as described in Subsections 838.02 through 838.04 of these rules, unless the annuity is permitted under Subsection 838.05.* ~~(2-8-06)T~~(2-8-06)T

01. Revocable Annuity. The surrender amount of a revocable annuity is a countable resource. (2-8-06)T

02. Irrevocable Annuity. An irrevocable annuity is an ~~*asset transfer if it does not provide fair market value to the participant. To provide fair market value, an irrevocable annuity must meet life expectancy and annual interest tests listed in Subsections 837.03 and 837.04 of this rule. The value for calculating the asset transfer penalty is the difference between the actual rate produced by the annuity and five percent (5%) per year. The sixty (60) month look-back applies*~~ annuity that under no circumstance can be sold or traded for value, including the sale of the stream of income from the annuity. The purchase *price* of an irrevocable annuity is *treated as* an asset transfer ~~*if it does not provide fair market value to the participant. The sixty (60) month look-back period applies. The irrevocable annuity provides fair market value to the participant if it passes all of the following tests*~~, *unless the requirements of Subsections 838.02.a, 838.02.b., 838.03 and 838.04 of these rules are met.* ~~(5-3-03)(2-8-06)T~~(2-8-06)T

~~*03*~~**a. Irrevocable Annuity Life Expectancy Test**. The participant's life expectancy, *as* shown in the following table, must equal or exceed the term of the annuity. Using Table ~~*837.03*~~ 838.02.a. compare the face value of the annuity to the participant's life expectancy at the purchase time. The annuity meets the life expectancy test if the participant's life expectancy equals or exceeds the term of the annuity. If the exact age is not in the Table, use the next lower age.

TABLE ~~*837.03*~~ 838.02.a. - LIFE EXPECTANCY TABLE

Age	Years of Life Remaining Male	Years of Life Remaining Female	Age	Years of Life Remaining Male	Years of Life Remaining Female
0	73.26	79.26	**74**	10.12	12.74
10	64.03	69.93	**75**	9.58	12.09
20	54.41	60.13	**76**	9.06	11.46
30	45.14	50.43	**77**	8.56	10.85
40	35.94	40.86	**78**	8.07	10.25
50	27.13	31.61	**79**	7.61	9.67
60	19.07	22.99	**80**	7.16	9.11

61	18.33	22.18	**81**	6.72	8.57
62	17.60	21.38	**82**	6.31	8.04
63	16.89	20.60	**83**	5.92	7.54
64	16.19	19.82	**84**	5.55	7.05
65	15.52	19.06	**85**	5.20	6.59
66	14.86	18.31	**86**	4.86	6.15
67	14.23	17.58	**87**	4.55	5.74
68	13.61	16.85	**88**	4.26	5.34
69	13.00	16.14	**89**	3.98	4.97
70	12.41	15.44	**90**	3.73	4.63
71	11.82	14.75	**95**	2.71	3.26
72	11.24	14.06	**100**	2.05	2.39
73	10.67	13.40	**110**	1.14	1.22

~~(3-15-02)~~~~(2-8-06)T~~(2-8-06)T

~~04~~b. ~~*Irrevocable Annuity*~~ **Annual Interest and Insurer Rating Test**. The annuity must produce annual interest of at least five percent (5%). A variable rate annuity meets the interest rate test if the average yearly rate for the most recent five (5) year period is five percent (5%) or more. ~~*The participant can*~~ To rebut the five percent (5%) interest test~~.~~, ~~*He*~~ the participant must show that single premium annuities were not offered by insurers when the annuity was purchased and it would not be practical to exchange the annuity for one with a higher interest rate. The ~~*I*~~insurer~~*s*~~ must be rated excellent or superior by an insurance rating firm ~~*such as A.M. Best Co*~~.

~~(5-3-03)~~(2-8-06)T

~~**c.** *Third Party Beneficiary Test. Effective February 8, 2006, the annuity must name the State of Idaho, Medicaid Estate Recovery, as follows:* (2-8-06)T~~

03. ***State Named as Beneficiary****. The purchase of an annuity is treated as an asset transfer unless the State of Idaho, Medicaid Estate Recovery is named as:* *(2-8-06)T*

~~*i*~~**a.** The remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or (2-8-06)T

~~*ii*~~**b.** The remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if the community spouse or a representative of the minor or disabled child disposes of any remainder for less than fair market value. (2-8-06)T

~~**d**~~**04.** **Equal Payment Test**. The annuity must provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made. (2-8-06)T

~~***05.*** ***Revocable Annuity****. The surrender amount of a revocable annuity is a resource.*~~

~~*Early surrender of a revocable annuity is not an asset transfer for less than fair market value.* (7-1-99)~~

05. ***Permitted Annuity****. The purchase of an annuity is not treated as an asset transfer if the annuity meets any of the descriptions in Sections 408(b), or 408(q), Internal Revenue Code; or is purchased with proceeds from an account or trust described in Sections 408(a), 408(c), or 408(p), Internal Revenue Code, or is a simplified employee pension as described in Section 408(k), Internal Revenue Code, or is a Roth IRA described in Section 408A, Internal Revenue Code.* *(2-8-06)T*

(BREAK IN CONTINUITY OF SECTIONS)

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. (3-20-04)

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 adult child must prove he provided nursing facility level medical care to the participant which permitted him to live at home rather than enter long-term care. The son or daughter must not have provided services as a paid Medicaid provider. ~~*(3-20-04)*~~(2-8-06)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. 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)

09. Assets Returned. All assets transferred for less than fair market value have been returned to the participant. (7-1-99)

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. (3-20-04)

11. Undue Hardship. ~~*Denying eligibility would cause an undue hardship.*~~ The participant, his representative, or the facility in which he resides may request the hardship waiver. The hardship waiver must be requested in writing within ten (10) days of the date of the asset transfer penalty notice. Undue hardship exists if any of the conditions in Subsections 841.11.a. through 841.11.~~c~~d. of these rules apply. ~~*(3-20-04)*~~(2-8-06)T

a. The participant proves he is not able to pay for his nursing facility services or his wavier services by any means ~~*and assigns his rights to recover the asset to the state of Idaho*~~. ~~*(3-20-04)*~~(2-8-06)T

b. The participant proves that he ~~*did not knowingly transfer the asset and assigns his rights*~~ has made reasonable efforts, consistent with his physical and financial ability, to recover the transferred asset ~~*to the state of Idaho*~~. The participant must fully cooperate with the state of Idaho in efforts to recover the transferred asset and, upon request, must assign his rights to recover the asset to the State of Idaho. ~~*(3-20-04)*~~(2-8-06)T

c. The participant proves he did not knowingly transfer the asset. (2-8-06)T

~~**e**~~**d.** ~~*The waiver participant proves he would be deprived of food, clothing or shelter if all income transferred to the trust is used only for waiver costs 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.*~~ The participant proves he would be deprived of food, clothing, shelter or other necessities of life if the asset transfer penalty is imposed and he assigns his rights to recover the asset to the State of Idaho. ~~*(3-20-04)*~~(2-8-06)T

12. 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 841.12.a. through 841.12.c. of these rules. (3-20-04)

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 and the lack of market demand was not created by a voluntary act of the participant. ~~*(7-1-99)*~~(2-8-06)T

c. The asset was transferred to settle a legal debt approximately equal to the fair

market value of the transferred asset. (7-1-99)

13. No Benefit to Participant. The participant received no benefit from the asset. This exception must meet one (1) of the conditions in Subsections 841.13.a. and 841.13.b. of these rules. (3-20-04)

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. The defect in the title was not created in an attempt to transfer assets to qualify for assistance or avoid recovery. ~~(7-1-99)~~(2-8-06)T

14. 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 and must assign recovery rights to the state of Idaho. (3-20-04)

842. -- 870. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0603

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendments to the temporary rules is January 1, 2007. This pending rule has been adopted by the agency and is now pending review by the 2007 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), 56-203(g), and 56-209(n), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the 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 following changes have been made to the Medicaid Workers with Disabilities section of rule to clarify requirements for eligibility and income limitations. Those clarifications include:

1. **Adding eligibility requirements and references to specific rules citing those requirements for Medicaid residency, citizenship, SSN, and child support cooperation;**
2. **Adding a resource amount allowed for a couple as well as citing specific rules; and**
3. **Adding a gross income test for an individual and a couple using earned and unearned income before exclusions or disregards.**

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. The original text of the proposed rule was published in the October 4, 2006, Idaho Administrative Bulletin, Vol. 06-10, pages 243 and 244.

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

Governing law requires that the Workers with Disabilities be effective on January 1, 2007.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on

the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

For the fiscal year 2007, the impact of this rule change to the State General Fund is $233,900 as appropriated in the 2007 Department Budget.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted. The Department held formal negotiations on June 14, 2006 in Boise, Idaho. The Negotiated Rulemaking Notice was published in the Idaho Administrative Bulletin, Vol. 06-6, on June 7, 2006, page 96.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Peggy Cook at (208) 334-5969.

DATED this 6th day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date for this temporary rule is January 1, 2007.

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

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

Date:	**Thursday, October 12, 2006**	**Tuesday, October 17, 2006**	**Tuesday, October 17, 2006**
Time:	**7:00 p.m.**	**7:00 p.m.**	**7:00 p.m.**
Place:	**DHW Region I Office** **Suite 102** **1120 Ironwood Dr.** **Coeur d'Alene, ID**	**Idaho Falls Public Library** **457 Broadway** **Idaho Falls, ID** **Phone: (208) 612-8455**	**DHW - Region IV Office** **1720 Westgate Dr.** **Suite D, Room 119** **Boise, 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 the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Many people on Medicaid want to work and recognize that employment is the way to end their dependence on Medicaid. However, individuals with disabilities, because of the cost of their support needs and the fact that most employers provide no insurance coverage for those supports, must curtail the number of work hours in order to keep their Medicaid

benefits. The Medicaid for Workers with Disabilities program will help these individuals gradually leave or lessen their reliance on Medicaid while increasing their work hours and income. These rule changes will implement the provisions of Section 56-209n, Idaho Code, adopted by the 2006 Legislature, by setting the criteria for eligibility in determining how a working disabled individual's income and resources will be calculated to establish Medicaid eligibility.

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

Governing law requires that the Workers with Disabilities be effective on January 1, 2007, and this rulemaking confers a benefit to those individuals eligible for the Workers with Disabilities program.

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

For the fiscal year 2007, the impact of this rule change to the State General Fund is $233,900 as appropriated in the 2007 Department Budget.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted. The Department held formal negotiations on June 14, 2006, in Boise, Idaho. Participants at the negotiations included; Comprehensive Advocacy Inc., Idaho Commission for the Blind and Visually Impaired, Idaho Division of Vocational Rehabilitation, State Independent Living Council, Mountain States Group, and the Idaho Council on Developmental Disabilities.The Negotiated Rulemaking Notice was published in the Idaho Administrative Bulletin, Vol. 06-6, on June 7, 2006, page 96.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Peggy Cook at (208) 334-5969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2006.

DATED this 11th day of August, 2006.

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) 334-6558 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

792. -- 79~~9~~8. (RESERVED).

799. MEDICAID FOR WORKERS WITH DISABILITIES.
An individual is eligible to participate in the Medicaid for Workers with Disabilities coverage group if the individual meets ~~*all of the following:*~~ *the requirements in Subsections 799.01 through 799.07 of this rule.* ~~*(1-1-07)T*~~(1-1-07)T

01. ~~***Age***~~ ***Non-Financial Requirements***. An individual must*:* (1-1-07)T

a. Be at least sixteen (16) but less than sixty-five (65) years of age~~.~~*;* ~~*(1-1-07)T*~~(1-1-07)T

b. *Meet the Medicaid residency requirement as described in Section 100 of these rules;* *(1-1-07)T*

c. *Meet the citizenship requirements as described in Sections 105 and 106 of these rules;* *(1-1-07)T*

d. *Meet the SSN requirements as described in Section 104 of these rules; and* *(1-1-07)T*

e. *Meet the child support cooperation requirements as described in Sections 703 through 706 of these rules.* *(1-1-07)T*

02. **Disability**. An individual must meet the medical definition for having a disability or blindness used by the Social Security Administration for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits. (1-1-07)T

03. **Employment**. An individual must be employed which may include self-employment. Proof of employment must be provided to the Department. Hourly wage or hours worked will not be used to determine employment. (1-1-07)T

04. **Resources**. ~~*A participant's*~~ Countable resources cannot exceed ten thousand dollars ($10,000) *for an individual or fifteen thousand dollars ($15,000) for a couple*. When calculating resources the following items will be excluded: ~~*(1-1-07)T*~~(1-1-07)T

a. Any resources excluded under Sections 200 through 299 of these rules; (1-1-07)T

b. A second ~~*car*~~ *vehicle as described in Sections 222 of these rules*; ~~*(1-1-07)T*~~(1-1-07)T

c. Life insurance policies; (1-1-07)T

d. Retirement accounts; and (1-1-07)T

e. Exempt trusts *as described in Section 872 of these rules*. ~~*(1-1-07)T*~~(1-1-07)T

05. ***Countable* Income**. ~~*A participant's*~~ Countable income~~, *after*~~ *is calculated using* exclusions and disregards ~~*used for AABD*~~ as described in Sections 300 through 499 of these rules~~,~~. (1-1-07)T

a. *An individual's countable income* cannot exceed five hundred percent (500%) of the current federal poverty guideline *for a household of one (1).* ~~*The gross earned income cannot be less than fifteen percent (15%) of the participant's total gross income.* *(1-1-07)T*~~(1-1-07)T

b. *A couple's countable income cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of two (2).* *(1-1-07)T*

06. ***Earned Income Test****. Gross income is the total of earned and unearned income before exclusions or disregards. Each individual's gross earned income must be at least fifteen percent (15%) of his total gross income to qualify.* *(1-1-07)T*

06. **Cost-Sharing** ~~***Premium***~~. A participant in the Medicaid for Workers with Disabilities coverage group may be required to ~~*pay a*~~ cost-~~*sharing premium*~~ *share.* ~~*A*~~ *If a* participant~~*'s premium for his*~~ *is required to cost*-share ~~*of*~~ *for* Medicaid*, the* costs ~~*is*~~ *are* determined under the provisions in IDAPA 16.03.18, "Medicaid Cost-Sharing." ~~*(1-1-07)T*~~(1-1-07)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0604

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The pending rule has been adopted by the agency and is now pending review by the 2007 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. This action is authorized pursuant to Section 56-202(b), Idaho Code.

DESCRIPTIVE SUMMARY: **The following is the required finding and concise statement of its supporting reasons for adopting a pending rule and a concise explanatory statement of the reasons for adopting the pending rule. The pending rule is being adopted as proposed. The original text of the proposed rule was published in the October 4, 2006, Idaho Administrative Bulletin, Vol. 06-10, pages 245 through 248. The Department negotiated this rulemaking to establish a method for the distribution of the annual cost-of-living adjustment increase. The rule reflects the negotiated percentages for the annual distribution between the basic allowance and the allowance for rent, utilities, and food.**

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: There is no anticipated fiscal impact increase to the state general fund. These changes are a distribution of funds budgeted for participants in the Aged and Disabled Waiver program.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Peggy Cook at (208) 334-5969.

DATED this 3rd day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date for this temporary rule is January 1, 2007.

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

DEPARTMENT OF HEALTH & WELFARE ***Docket No. 16-0305-0604***
Rules Governing Eligibility for Aid to the Aged/Blind/Disabled ***PENDING RULE***

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

October 11, 2006 - 6:00 p.m.
Medicaid Region IV Office
1720 Westgate Dr., Suite D, Rm 119
Boise, Idaho

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

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

Medicaid participants on the Aged and Disabled Waiver program, who reside in a residential care facility or certified family home, are budgeted a basic allowance for their out-of-pocket costs and an allowance for the cost of rent, utilities and food. The Department negotiated this rulemaking to establish a method for the distribution of the annual cost-of-living adjustment increase to the two allowances. These rule changes reflect those negotiated percentages for the annual distribution between the basic allowance and the allowance for rent, utilities, and food.

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

In order to have rules in effect for distribution of the next cost-of-living annual increase, these rules are being adopted as temporary rules to meet this deadline.

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

There is no anticipated fiscal impact increase to the state general fund. These changes are a distribution of funds budgeted for participants in the Aged and Disabled Waiver program.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted with Certified Family Home Providers, Residential Care or Assisted Living Facility Providers, Idaho Health Care Association, and the Idaho Residential Supported Living Association.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Peggy Cook at (208) 334-5969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2006.

DATED this 22nd day of August, 2006.

Sherri Kovach, Program Supervisor
DHW - Administrative Procedures Section
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P.O. Box 83720, Boise, Idaho 83720-0036
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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

500. FINANCIAL NEED AND AABD CASH AMOUNT.
To be eligible for AABD cash and Medicaid, ~~T~~the participant must have financial need. The participant has financial need if his allowances, as described in Sections 501 through 513 of these rules, are more than his income. The amount of financial need is the amount that the allowances exceed income. If the participant is eligible, his AABD cash payment is the difference between his financial need and his countable income. If the difference is not an even dollar amount, AABD cash is paid at the next higher dollar. AABD cash is paid electronically as set forth in IDAPA 16.03.20, "Rules Governing Electronic Payments (EP) of Public Assistance, Food Stamps, and Child Support." ~~(3-30-01)~~(1-1-07)T

501. BASIC ALLOWANCE.
Each participant receives a basic allowance unless he lives in a nursing facility. The basic allowance for each living arrangement is listed in Subsections 501.01 through 501.0~~5~~4 of these rules. The Semi-Independent Group Residential Facility, Room and Board, Residential and Assisted Living Facility and Certified Family Home basic allowances are those in effect January 1, 2001. They do not change with the annual cost-of-living increase in the federal SSI benefit amount. ~~(5-3-03)~~(1-1-07)T

01. Single Participant. Through December 31, 2000, a participant is budgeted five hundred forty-five dollars ($545) monthly as a basic allowance when living in a situation described in Subsections 501.01.a. through 501.01.e. of these rules. Beginning January 1, 2001, the basic allowance increase for a single participant is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. ~~(3-30-01)~~(1-1-07)T

a. Living alone. (7-1-99)

b. Living with his ineligible spouse. (7-1-99)

c. Living with another participant who is not his spouse. (7-1-99)

d. Living in another's household. This includes a living arrangement where the participant purchases lodging (room) and meals (board) from his parent, child or sibling.

(3-30-01)

e. Living with his TAFI child. (7-1-99)

02. Couple or Participant Living with Essential Person. Through December 31, 2000, a participant living with his participant spouse or his essential person is budgeted seven hundred sixty-eight dollars ($768) monthly as a basic allowance. Beginning January 1, 2001, the basic allowance increase for a couple is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a couple. The increase may be rounded up. (3-30-01)

03. SIGRIF. A participant living in a semi-independent group residential facility (SIGRIF) is budgeted three hundred forty-nine dollars ($349) monthly as a basic allowance. (7-1-99)

~~***04. Room and Board Home**. A participant living in a room and board home, as defined in Section 512, is budgeted seventy-seven dollars ($77) monthly as a basic allowance.* (3-1-06)T~~

0~~5~~4. Personal Care Supplement. A participant living in a Residential and Assisted Living Facility, or Certified Family Home with state plan personal care services, is budgeted five hundred and twenty dollars ($520) monthly as a Basic Allowance, if he does not have enough income to pay his provider for his rent, utilities and food. To receive a Personal Care Supplement, the participant's income after exclusions and disregards must be less than his Basic Allowance. The amount of the supplement is the remainder when income, less exclusions and disregards, is subtracted for the basic allowance. Beginning January 1, 2003, the basic allowance increase is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. ~~(5-3-03)~~(1-1-07)T

(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. (1-1-07)T

01. Budgeted Room and Board Allowance. Beginning January 1, 2006, a participant living in a room and board home is budgeted six hundred ninety-three dollars ($693). Beginning January 1, 2007, the Room and Board allowance ~~*increase is the dollar amount*~~ will be adjusted annually by eighty percent (80%) of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The room and board allowance increase will be rounded up to the next dollar. ~~(1-1-06)T~~(1-1-07)T

02. Basic Allowance for Participant in Room and Board Home. A participant living in a room and board home is budgeted seventy-seven dollars ($77) monthly as a basic allowance. Beginning January 1, 2007, this basic allowance will be adjusted annually by twenty percent (20%) of the annual cost-of-living increase in the federal SSI benefit rate for a single

person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded down to the nearest dollar. (1-1-07)T

513. RESIDENTIAL CARE ~~AND~~ OR ASSISTED LIVING FACILITY AND CERTIFIED FAMILY HOME ALLOWANCES.
A participant living in a Residential Care ~~and~~ or Assisted Living Facility (RALF), ~~(~~in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho,"~~)~~ or a Certified Family Home (CFH), ~~(~~in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes,"~~) with State Plan Personal Care Services,~~ is budgeted a basic allowance of seventy-seven dollars ($77) monthly. Beginning January 1, 2007, this basic allowance will be adjusted annually by twenty percent (20%) of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded down to the nearest dollar. (1-1-07)T

01. Budgeted Monthly Allowance Based On Level of Care. A participant is ~~also~~ budgeted a monthly allowance for care based on his assessed level of care as described in Section 514 of these rules. If the participant ~~gets~~ receives a lower State Plan Personal Care Service (PCS) level of ~~RALF or CFH~~ care than his assessed level, his allowance is for the lower level of care. These allowances are used to determine ~~eligibility~~ income limits for Medicaid if the participant does not qualify for the Home and Community Based Services Waivers. These allowances are only used for AABD cash when the participant is entitled to the DD Waiver in accordance with Section 789~~, "Developmentally Disabled (DD) Waiver,"~~ of ~~this~~ these rules. If the participant does not require ~~the RALF or CFH~~ one (1) of the State Plan PCS levels of care, his eligibility and allowances are based on the Room and Board rate in Section 512 of these rules.
~~(3-1-06)T~~(1-1-07)T

0~~1~~2. Care Levels and Monthly Allowances. Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513.02 of these rules. Beginning January 1, 2007, the RALF and CFH allowances ~~increase by the full dollar amount~~ for participants living in a RALF or CFH on State Plan PCS will be adjusted annually by eighty percent (80%) of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. This increase will be rounded up to the next dollar.

TABLE 513.02 - STATE PLAN PCS CARE LEVELS AND ALLOWANCES AS OF 1-1-06		
	Level of Care	Monthly Allowance
a.	Level I	Eight hundred and thirty-five dollars ($835)
b.	Level II	Nine hundred and two dollars ($902)
c.	Level III	Nine hundred and sixty-nine dollars ($969)

~~(1-1-06)T~~(1-1-07)T

0~~2~~3. CFH Operated by Relative. A participant living in a Certified Family Home (CFH) operated by his parent, child or sibling is not entitled to the CFH State Plan PCS allowances. He may receive the allowance for a person living with a relative as described in

Section 501 of these rules. A relative for this purpose is the participant's parent, child, sibling, aunt, uncle, cousin, niece, nephew, grandparent or grandchild by birth, marriage, or adoption.

~~(3-15-02)~~(1-1-07)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0605

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 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 56-202(b), 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 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 complete text of the proposed rule was published in the July 5, 2006, Idaho Administrative Bulletin, Vol. 06-7, pages 59 through 62.

The amendments to these rules are the result of comments received during the comment period. The following are specific changes made to the proposed rules:

1) Section 005 - added definitions for long-term care, Title XIX, Title XXI, and amended definitions for annuity and Medical Assistance Rules.
2) Section 737 - added a reference to the CFR for clarification of an excluded home.
3) Section 871 - added a reference to the CFR for clarification when a home and adjoining property looses its exclusion for eligibility purposes.

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

There is no anticipated fiscal impact to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Peggy Cook at (208) 334-5969.

DATED this 28th day of September, 2006.

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0305-0605***
Eligibility for Aid to the Aged, Blind and Disabled (AABD) ***PENDING RULE***

THIS NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

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

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

Date:	**Thursday, July 13, 2006**
Time:	**10:00 am**
Place:	**Department of Health and Welfare** **Pete T. Cenarussa Bldg., 6th Floor Conference Room** **450 W. State Street, Boise, ID**

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of the substance and purpose of the proposed rulemaking:

Federal law has changed dued to the passage of the Deficit Reduction Act (DRA) of 2005 requiring the Department to update and clarify several sections of this chapter of rule. The rules that apply to trusts, life estates, and annuities also apply to estate recovery rules. These rules are being amended to help prevent the sheltering of assets. Clarification has been made to the section dealing with "Inheritance," "Resources Excluded from Assessment," "Treatment of Trusts," and new definitions were added for "annuities" and "assets".

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

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. There is no anticipated fiscal impact increase to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted with parties that had expressed concerns with a previous rulemaking on these issues as well as the DRA. The Department held informal negotiations with the Trust and Estate Professionals of Idaho on this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Peggy Cook at (208) 334-5969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 26, 2006.

DATED this 16th day of June, 2006.

DEPARTMENT OF HEALTH AND WELFARE **Docket No. 16-0305-0605**
Eligibility for Aid to the Aged, Blind and Disabled (AABD) **PENDING RULE**

Sherri Kovach
Program Supervisor
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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

005. DEFINITIONS.
These definitions apply to IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)": (7-1-99)

01. AABD Cash. An EBT payment to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments. (5-3-03)

02. Applicant. A person applying for public assistance from the Department, and whose application is
not fully processed. (7-1-99)

03. Annuity. A right to receive periodic payments, either for life, a term of years, or other interval of time, whether or not the initial payment or investment has been annuitized. It includes contracts for single payments where the single payment represents an initial payment or investment together with increases or deductions for interest or fees rather than an actuarially-based payment from an insurance pool. It does not include an annuity: ( )

a. Described in Sections 408(b) or 408(q), Internal Revenue Code of 1986; or ( )

b. Purchased with proceeds from an account or trust described in Sections 408(a), 408(c), or 408(p). Internal Revenue Code, a simplified employee pension as described in Section 408(k), Internal Revenue Code, or a Roth IRA described in Section 408A, Internal Revenue Code. ( )

04. Asset. Includes all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to, but does not receive because of action by: ( )

a. The individual or such individual's spouse; ( )

b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or ( )

c. A person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse. ( )

0~~3~~5. Asset Transfer for Sole Benefit. An asset transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. (5-3-03)

0~~4~~6. Child. A child is under age eighteen (18), or under twenty-one (21) and attending school, college, university, or vocational or technical training designed to prepare him for gainful employment. A child is not married. A child is not the head of a household. (7-1-99)

0~~5~~7. Department. The Department of Health and Welfare. (7-1-99)

0~~6~~8. Direct Deposit. The electronic deposit of a participant's AABD cash to the participant's personal account with a financial institution. (7-1-99)

0~~7~~9. Electronic Benefits Transfer (EBT). A method of issuing AABD cash to a participant, a participant's guardian or a holder of a limited power of attorney for EBT payments for a participant. EBT rules are in IDAPA 16.03.20, "Rules Governing Electronic Payments of Public Assistance, Food Stamps and Child Support". (7-1-99)

~~08~~10. Essential Person. A person of the participant's choice whose presence in the household is essential to the participant's well-being. The essential person provides the services a participant needs to live at home. (5-3-03)

~~09~~11. Fair Market Value. The fair market value of an asset is the price for which the asset can be reasonably expected to sell on the open market, in the geographic area involved. (5-3-03)

***12. Long-Term Care**. Long-term care services are services provided to an institutionalized individual as defined in 42 U.S.C. 1396(c)(1)(c). ( )*

1~~0~~3. Medicaid. The Federally-funded program for medical care (Title XIX, Social Security Act). (5-3-03)

1~~1~~4. Medical Assistance Rules. Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "~~*Rules Governing the Medical Assistance Program*~~ *Medicaid Basic Plan Benefits,*" *and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."* (7-1-99)

1~~2~~5. Medicaid for Families With Children Rules. Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children". (7-1-99)

1~~3~~6. Participant. An individual applying for or receiving assistance. (7-1-99)

1~~4~~7. Sole Beneficiary. The only beneficiary of a trust, including a beneficiary during the grantor's life, a beneficiary with a future interest, and a beneficiary by the grantor's will. (7-1-99)

1~~5~~8. TAFI Rules. Idaho Department of Health and Welfare Rules, IDAPA 16.03.08, "Rules Governing Temporary Assistance for Families in Idaho". (7-1-99)

19. ***Title XIX***. *Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources.* ( )

20. ***Title XXI***. *Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children.* ( )

~~16~~21. **Working Day**. A calendar day when regular office hours are observed by the state of Idaho. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

280. INHERITANCE.
An inheritance is cash, a right, including probate allowances, trust payments and annuities, or noncash items received as the result of someone's death. Cash or noncash items in an inheritance are income the month received and a resource the next month. Participants are required to make claims and take all reasonable action necessary to obtain any inheritance to which they may be entitled. Failure to make such claims or take reasonable steps to obtain an inheritance is an asset transfer. A contested inheritance is not counted as a resource until the contest is settled and money is distributed. ~~(7-1-99)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

737. RESOURCES EXCLUDED FROM ASSESSMENT.
Resources excluded in determining AABD cash are excluded in determining the couple's total combined FSI resources except: ~~*There is no limit on the total value of household goods and personal effects and one (1) automobile is excluded regardless of its value. Any additional automobiles are countable resources in the amount of their equity value.*~~ ~~(7-1-99)~~( )

01. Resources For Sale. Excess resources offered for sale, are not excluded from the couple's total combined resources for the FSI resource assessment. ~~(7-1-99)~~( )

02. Jointly Owned Real Property. Jointly owned real property that is not the principal residence of the participant, is not excluded, if the community spouse is the joint owner. ~~(7-1-99)~~( )

03. Excluded Home. *As defined in 42 U.S.C. 1396r-5(c)(5),* an excluded home placed in trust retains its exclusion for purposes of the resource assessment. ( )

(BREAK IN CONTINUITY OF SECTIONS)

871. TREATMENT OF TRUSTS.
These trust treatment rules apply to all Medicaid participants. These rules apply to trusts established with the participant's assets on August 11, 1993 or later, and to *amounts placed in* trusts ~~*funded*~~ *on or after* August 11, 1993 ~~*or later*~~. ~~*This*~~ Section 871 *of these rules* does not apply to an irrevocable trust if the participant meets the undue hardship exemption in Subsection 841.11 of these rules. Assets transferred to a trust are subject to the asset transfer penalty. Section 871 does not apply to a trust created with assets other than those of the individual, including a trust established by a will. ~~(4-11-06)~~( )

01. Revocable Trust. Revocable trusts are treated as listed in Subsections 871.01.a. through 871.01.d. of these rules. A revocable burial trust is not a trust for the purposes of Subsection 871.01 of these rules. (4-11-06)

a. The body (corpus) of a revocable trust is a resource. (7-1-99)

b. Payments from the trust to or for the participant are income. (7-1-99)

c. Any other payments from the trust are an asset transfer, triggering an asset transfer penalty period. (7-1-99)

d. *As defined in 42 U.S.C. 1396p(e)(5),* the home and adjoining property loses its exclusion *for eligibility purposes* when transferred to a revocable trust, unless the participant or spouse is the sole beneficiary of the trust. The home is excluded again if removed from the trust. The exclusion restarts the ~~*next*~~ month *following the month the home was removed from the trust*. ~~(7-1-99)~~( )

02. Irrevocable Trust. Irrevocable trusts are treated as listed in Subsections 871.02.a. through 871.02.g. of these rules. (4-11-06)

a. The part of the body of an irrevocable trust, from which corpus or income payments could be made to or for the participant, is a resource. (7-1-99)

b. Payments made to or for the participant are income. (7-1-99)

c. Payments from the trust for any other reason are asset transfers, triggering the asset transfer penalty. (7-1-99)

d. Any part of the trust from which payment cannot be made to, or for the benefit of, the participant under any circumstances, is an asset transfer. (7-1-99)

e. The effective date of the transfer is the date the trust was established, or the date payments to the participant were foreclosed. (7-1-99)

f. The value of the trust, for calculating the transfer penalty, includes any payments made from that portion of the trust after the date the trust was established or payments were

foreclosed. (7-1-99)

g. An irrevocable burial trust is not subject to treatment under Subsection 871.02 of these rules, unless funds in the trust can be paid for a purpose other than the participant's funeral and related expenses. The trust can provide that funds not needed for the participant's funeral expenses are available to reimburse Medicaid, or to go to the participant's estate. (4-11-06)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0606

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 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 and HCR 53 (2006).

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 complete text of the proposed rule was published in the October 4, 2006, Idaho Administrative Bulletin, Vol. 06-10, pages 249 and 250.**

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

The implementation of this rule change is projected to result in a savings of $640,888 to the state general fund for fiscal year 2007. NOTE: This is a savings in the Division of Medicaid's Trustee and Benefit budget; it is not a reduction in the Division of Welfare's budget.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Peggy Cook at (208) 334-5969.

DATED this 3rd day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b) and 56-203(g), Idaho Code, and HCR 53 (2006).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an

agency, not later than Wednesday, October 18, 2006.

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:

At the recommendation of the 2006 legislature (HCR 53), the Department is proposing a rule that requires Medicare-eligible individuals to enroll in Medicare as a condition of eligibility for Idaho Medicaid. The purpose of this change is to reduce Medicaid costs while at the same time maintaining the same level of medical benefits to individuals who are eligible for both Medicaid and Medicare.

This rule change also brings the rules into compliance with this same eligibility requirement that now appears in the newly rewritten Medicaid State Plan.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. The implementation of this rule change is projected to result in a savings of $640,888 to the state general fund for fiscal year 2007. NOTE: This is a savings in the Division of Medicaid's Trustee and Benefit budget; it is not a reduction in the Division of Welfare's budget.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking was done to align with legislation passed during the 2006 legislative session and with recent changes to Department's Medicaid State Plan.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Peggy Cook at (208) 334-5969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, October 25, 2006.

DATED this 22nd day of August, 2006.

Sherri Kovach
Program Supervisor
DHW – Administrative Procedures Section
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P.O. Box 83720
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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

707. ~~*GROUP HEALTH PLAN ENROLLMENT REQUIREMENT*~~ APPLICATION REQUIREMENTS FOR POTENTIAL MEDICAL COVERAGE.

01. Group Health Plan Enrollment Requirement. ~~*The*~~ Each participant must apply for and enroll in a cost-effective employer group health plan as a condition of eligibility for Medicaid. Medicaid coverage must not be denied, delayed, or stopped pending the start of a participant's group health insurance coverage. A child entitled to enroll in a group health plan must not be denied Medicaid coverage solely because his caretaker fails to apply for the child's enrollment. ~~*(3-30-01)*~~(____)

02. Medicare Enrollment Requirement. Each participant who may be eligible for Medicare must apply for all parts of Medicare parts A, B, and D for which he is likely to be eligible, as a condition of eligibility for Medicaid. (____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-0607

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 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 and 56-250 through 56-257, 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 complete text of the proposed rule was published in the November 1, 2006, Idaho Administrative Bulletin, Vol. 06-11, pages 46 through 50.

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

There is no fiscal impact to the state General Fund due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Peggy Cook at (208) 334-5969.

DATED this 30th day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 1, 2006.

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 Sections 56-202, and 56-250 through 56-257.

DEPARTMENT OF HEALTH & WELFARE ***Docket No. 16-0305-0607***
Eligibility for Aid to the Aged, Blind and Disabled ***PENDING RULE***

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 November 15, 2006.

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

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

The current Traumatic Brain Injury (TBI) Waiver expired on September 30, 2006. The Department needs to provide TBI Waiver participants a service plan that is effective on October 1, 2006. The coverage for TBI participants has been moved to the A&D Waiver Services coverage found in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." The A&D Waiver has similar eligibility criteria for the level of care and services, and will provide TBI Waiver participants continued coverage without disruption. The eligibility criteria for the TBI Waiver is being deleted in this rulemaking. The A&D eligibility section was revised and now includes participants aged sixty-five (65) and older. This age group has been eligible and is included in the IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" rule; however, it needed to be added to this rule also. Also, effected sections of this rule have been updated by deleting the reference to IDAPA 16.03.09, "Rules Governing the Medical Assistance Program" and replacing it with the new IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits."

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is being done to confer a benefit to current Traumatic Brain Injury (TBI) Waiver participants.

FEE SUMMARY: There is no fee or charge being imposed or increased in this docket.

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

There is no fiscal impact to the state General Fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes to rule are being made to benefit TBI Waiver participants.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Peggy Cook at (208) 334-5969.

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 Wednesday, November 22, 2006.

DATED this 20th day of September, 2006.

Sherri Kovach
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THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

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 long-term care is determined using IDAPA 16.03.~~09~~10, "~~*Rules Governing the Medical Assistance Program*~~ Medicaid Enhanced Plan Benefits."
~~*(3-20-04)*~~(10-1-06)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. (3-20-04)

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. (3-20-04)

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. (3-20-04)

a. Income excluded or disregarded, in determining eligibility for AABD cash, is not counted. (3-20-04)

b. The September 1972 RSDI increase is not counted. (3-20-04)

c. 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. (3-20-04)

d. 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. (3-20-04)

e. Income paid into an income trust exempt from counting for Medicaid eligibility under Subsection 872.02 of these rules is used for patient liability. Income paid to the trust and not used for patient liability, is subject to the asset transfer penalty. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

785. CERTAIN DISABLED CHILDREN.
A disabled child, not eligible for Medicaid outside a medical institution, is eligible for Medicaid if he meets the conditions in Subsections 785.01 through 785.07 of these rules. (3-15-02)

01. Age. Is under nineteen (19) years old. (7-1-99)

02. AABD Criteria. 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. Income Limit. Has monthly income not exceeding three (3) times the Federal SSI benefit payable monthly to a single person. (7-1-99)

05. Eligible for Long Term Care. Meets the medical conditions for long-term care in IDAPA 16.03.~~*09*~~10, "~~*Rules Governing the Medical Assistance Program," Subsection 160.09*~~ Medicaid Enhanced Plan Benefits." ~~*(7-1-99)*~~(10-1-06)T

06. Appropriate Care. Is appropriately cared for outside a medical institution, under a physician's plan of care. (7-1-99)

07. Cost of Care. Can be cared for cost effectively outside a medical institution. The estimated cost of caring for the child must not exceed the cost of the child's care in a hospital, nursing facility, or ICF-MR. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

787. HOME AND COMMUNITY BASED SERVICES (HCBS).

An aged, blind or disabled participant, who is not income eligible for SSI or AABD cash, in his own home or community setting, is eligible for Medicaid if he meets the conditions in Subsections 787.01 through 787.07 of these rules, and meets all requirements in one (1) of the waiver Sections 788 through 79~~1~~0 of these rules. ~~(3-20-04)~~(10-1-06)T

01. Resource Limit. Meets the AABD single person resource limit. (3-20-04)

02. Income Limit. Income of the participant must not exceed three (3) times the Federal SSI monthly benefit for 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. (3-20-04)

03. Maintained in the Community. The applicant must be able to be maintained safely and effectively in his own home or in the community with the waiver services. (3-20-04)

04. Cost of Care. The cost of the participant's care must be determined to be cost effective as provided in IDAPA 16.03.~~09~~10, "~~*Rules Governing the Medical Assistance Program*~~ Medicaid Enhanced Plan Benefits." ~~(3-20-04)~~(10-1-06)T

05. Waiver Services Needed. The participant must need and receive, or be likely to need and receive, waiver services for thirty (30) consecutive days. The participant is ineligible when there is a break in need for, or receipt of, waiver services for thirty (30) consecutive days. (3-20-04)

06. Effective Date. Waiver services are effective the first day the participant is likely to need and receive waiver services. Medicaid begins the first day of the month in which the first day of approved waiver services are received. (3-20-04)

07. Annual Limit. The Department limits the number of participants approved for waiver services each year. A participant who applies for waiver services after the annual limit is reached, must be denied waiver services. (3-20-04)

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".*~~ In order to be eligible for the Aged and Disabled (A&D) Waiver, the participant must: ~~(3-20-04)~~(10-1-06)T

01. Age Eighteen Through Sixty-Four. Be eighteen (18) through sixty-four (64) years old and meet both the disability criteria, as provided in Subsection 156 of these rules, and need nursing facility level of care as provided in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits"; or (10-1-06)T

02. Age Sixty-Five or Older. Be age sixty-five (65) or older and need nursing facility level of care as provided in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." (10-1-06)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*~~ Medicaid Enhanced Plan Benefits." ~~*(3-20-04)*~~(10-1-06)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".* *(3-20-04)*~~

79~~*1*~~0. 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. (3-20-04)

79~~*2*~~1. -- 798. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

802. WOMAN DIAGNOSED WITH BREAST OR CERVICAL CANCER.
A woman not otherwise eligible for Medicaid and meeting the conditions in Subsections 802.01 through 802.06 of this rule is eligible for Medicaid for the duration of her cancer treatment. Medicaid income and resource limits do not apply to this coverage group. (5-3-03)

01. Diagnosis. The participant is diagnosed with breast or cervical cancer through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early detection Program. (3-15-02)

02. Age. The participant is under age sixty-five (65). (3-15-02)

03. Creditable Health Insurance. The participant is uninsured or, if insured, the plan does not cover her type of cancer. (3-15-02)

04. Non-Financial Eligibility. The participant meets the Medicaid non-financial eligibility requirements in Sections 100 through 108 and Sections 166 and 167 of these rules. (3-15-02)

05. Medical Support Cooperation. The participant meets the medical support cooperation requirement in Sections 702 through 706 of these rules. (3-15-02)

06. Group Health Plan Enrollment. The participant meets the requirement to enroll in available cost-effective employer group health insurance. (3-15-02)

07. Presumptive Eligibility. The Department can presume the participant is eligible for Medicaid, before a formal Medicaid eligibility determination is made. A clinic authorized to

screen for breast or cervical cancer by the National Breast and Cervical Cancer Early Detection Program makes the presumptive eligibility determination. The clinic tells the participant how to complete the formal Medicaid determination process. The Medicaid notice and hearing rights do not apply to presumptive eligibility. No overpayment occurs if the formal Medicaid determination finds the participant is not eligible. (5-3-03)

08. End of Treatment. The Division of Medicaid determines the end of treatment date according to IDAPA 16.03.~~*09*~~10, "~~*Rules Governing the Medical Assistance Program," Section 013*~~ Medicaid Enhanced Plan Benefits." ~~*(5-3-03)*~~(10-1-06)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.08 - RULES GOVERNING TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO

DOCKET NO. 16-0308-0601

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2007, 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 56-202, Idaho Code, and 45 CFR Parts 260 - 265.

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 complete text of the proposed rule was published in the October 4, 2006, Idaho Administrative Bulletin, Vol. 06-10, pages 251 and 252. These proposed rule changes will become effective July 1, 2007**.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: There may be a slight increase in the number of families approved for TAFI, but there will be no fiscal impact to the state general funds. The Temporary Assistance to Needy Families is a federal block grant used to fund the TAFI program.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Genie Sue Weppner at (208) 334-5656.

DATED this 3rd day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-202, Idaho Code, and 45 CFR Parts 260 - 265.

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 18, 2006.

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:

Families who apply for Temporary Assistance for Families in Idaho (TAFI) monies need reliable transportation in order to seek and maintain employment, to further their education, and to transport their children. Idaho's current policy of counting the value of a family's vehicle in determining their eligibility for TAFI often forces the family to sell their reliable vehicles in order to meet their family's most basic financial needs. Because of Idaho's restrictive rules, those who are most hurt by the current rules are two (2)-parent households, working adults, households suffering recent job loss, and those living in rural Idaho. The proposed changes will exclude one (1) vehicle per adult family member in a TAFI household. These changes will promote and support the working families in Idaho and are especially valuable to families living in rural Idaho who have limited access to public transportation. Proposed changes will become effective July 1, 2007.

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

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

There may be a slight increase in the number of families approved for TAFI, but there will be no fiscal impact to the state general funds. The Temporary Assistance to Needy Families is a federal block grant used to fund the TAFI program.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule change was due to federal law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Genie Sue Weppner at (208) 334-5656.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 25, 2006.

DATED this 14th day of August, 2006.

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) 334-6558 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

207. ~~COUNTING~~ VEHICLES ~~VALUE~~.
The Department counts the resource value of a vehicle~~s~~ as described in Subsections 207.01 ~~through~~ and 207.0~~7~~2 of these rules as long as the vehicle is used primarily for transportation and not for recreational use. The value of any vehicle that is primarily for recreational use counts toward the household's resource limit. ~~(3-15-02)~~( )

01. ~~Vehicle Used to Transport Disabled Household Member~~. ~~The Department does not count as a resource the value of any vehicle used to transport a physically disabled household member, regardless of the purpose of the transportation, even if that person is a disqualified or an ineligible household member.~~ **Exclude One Vehicle Per Adult**. The value of one (1) vehicle per adult in the TAFI household is excluded beginning with the highest valued vehicle. ~~(3-15-02)~~( )

02. ~~Vehicle Necessary for Household Function~~. ~~The Department does not count as a resource the value of any vehicle meeting one (1) of the conditions in Subsections 207.02.a. through 207.02.d.~~ **All Other Vehicles Subject to Federal Regulations**. All other vehicles in the household will have their values counted as provided in the Federal Food Stamp Program under 7 CFR 273.8. ~~(3-15-02)~~( )

~~**a.** The vehicle produces income consistent with its Fair Market Value (FMV). (3-15-02)~~

~~**b.** The household uses the vehicle as their home. (3-15-02)~~

~~**c.** A migrant farm worker uses the vehicle to travel from job to job. (3-15-02)~~

~~**d.** The household uses the vehicle to carry their primary source of heating fuel or water. (3-15-02)~~

~~**03. Vehicle Value Less Than Fifteen Hundred Dollars**. The Department does not count as a resource the value of any vehicle having a fair market value, or equity value, of less than fifteen hundred dollars ($1,500). (3-15-02)~~

~~**04. Adults and Vehicle Value Greater Than Four Thousand Six Hundred Fifty Dollars**. The Department counts as a resource the FMV, above four thousand six hundred fifty dollars ($4,650), of one (1) vehicle per adult household member, regardless of use. (3-15-02)~~

~~**05. Persons Under Age Eighteen and Vehicle Value Greater Than Four Thousand Six Hundred Fifty Dollars**. The Department counts as a resource the FMV, above four thousand six hundred fifty dollars ($4,650), of one (1) vehicle per household member under age eighteen (18), when used by that person to commute to work, school, training or to look for work. This applies even if another vehicle was already totally excluded for that household member. (3-15-02)~~

~~***06. Other Vehicles**. The Department counts as a resource the FMV, minus encumbrances or equity value, whichever is higher, of licensed or tagged vehicles, snowmobiles, boats, aircraft or other recreational vehicles not falling under the provisions of Subsections 207.01 through 207.05. (3-15-02)***~~

~~***07. Unlicensed Vehicles**. The Department counts as a resource the equity value of any unlicensed vehicles. (3-15-02)***~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.08 - RULES GOVERNING TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO

DOCKET NO. 16-0308-0602

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The pending rule has been adopted by the agency and is now pending review by the 2007 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 56-202, Idaho Code, and 45 CFR Parts 260 - 265.

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 the original proposed rule published. The complete text of the proposed rule was published in the October 4, 2006, Idaho Administrative Bulletin, Vol. 06-10, pages 253 through 256.**

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: There may be a slight increase in the number of families approved for TAFI, but there will be no fiscal impact to the state general funds. The Temporary Assistance to Needy Families is a federal block grant used to fund the TAFI.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Genie Sue Weppner at (208) 334-5656.

DATED this 3rd day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 1, 2006.

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 56-202, Idaho Code, and 45 CFR Parts 260 - 265.

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 20, 2006.

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

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

In order for the Department to help meet federal requirements and improve the work participation rates in the Temporary Assistance for Families in Idaho (TAFI) program, these rules are being amended. The following changes will help meet and assist in improving the work skills and training necessary for the work participants to be successful in obtaining jobs. To meet this responsibility the following changes are being made:

1) The Work Incentive table is being updated to the current monthly grant amount.

2) The advance notification requirement is being removed when a work participant fails to meet his personal obligations for participating in the program.

3) Required Administrative Procedures Act sections not currently in rule are being added.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reason: These rule changes are necessary for compliance with deadlines in governing law for this federal program.

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

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

There is no anticipated fiscal impact to the sate general funds as a result of this rule change. These changes will help the state meet the work participation rate requirements and avoid penalties which could reduce the amount of the block grant or cause the state to replace the penalty amount if these rates are not met.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes were due to requirements in the reauthorization of the Temporary Assistance to Needy Families (TANF) federal block grant.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN

COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Genie Sue Weppner at (208) 334-5656.

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 27, 2006.

DATED this 22nd day of August, 2006.

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) 334-6558 fax
kovachs@idhw.state.id.us e-mail

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
The Idaho Department of Health and Welfare is authorized to adopt rules for the administration of public assistance programs ~~*by*~~ under Section 56-202, Idaho Code, and 45 CFR Parts 260 - 265.
~~*(7-1-98)*~~(10-1-06)T

001. TITLE, ~~*AND*~~ SCOPE, AND PURPOSE.

01. Title. These rules are ~~*known and will be*~~ cited as the ~~*Rules of the Idaho Department of Health and Welfare,*~~ IDAPA 16.03.08, "Rules Governing the Temporary Assistance for Families in Idaho (TAFI) Program." (10-1-06)T

02. Scope. These rules provide standards for the administration of the TAFI program.
~~*(7-1-98)*~~(10-1-06)T

03. Purpose. The purpose of these rules are to help participants in the Temporary Assistance for Families in Idaho (TAFI) program to obtain jobs by providing assistance and support. This focus requires more than government alone can or should provide. This program requires relationships where participants, families, local communities and employers work together to help participants obtain employment and achieve self-reliance. Department resources for applicants and participants will be provided in the following priority order, if applicable: Child Support Services (CSS); child care assistance; other Department services such as Medicaid, Food Stamps, Aid to the Aged, Blind and Disabled (AABD); and TAFI. (10-1-06)T

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection as described in Sections 005 and 006 of these rules. (10-1-06)T

003. ADMINISTRATIVE APPEAL.
Administrative appeals are governed by IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (10-1-06)T

004. ~~*TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO*~~ INCORPORATION BY REFERENCE.
~~*The goals of Temporary Assistance for Families in Idaho (TAFI) are jobs for participants and support for both personal and family responsibility. This focus requires more than government alone can or should provide. This program requires relationships where participants, families, local communities and employers work together to help participants obtain employment and achieve self-reliance. Department resources for applicants and participants will be provided in the following priority order, if applicable: Child Support Services (CSS); child care assistance; other Department services such as Medicaid, Food Stamps, Aid to the Aged, Blind and Disabled (AABD); and TAFI.*~~ No documents have been incorporated by reference in this chapter of rules. ~~*(7-1-98)*~~(10-1-06)T

005. ~~*RULE AVAILABILITY*~~ OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE -- INTERNET WEBSITE.
~~*Copies of these rules are available from the Administrative Procedures Section, 10th Floor, Towers Building -- 450 West State Street, P.O. Box 83720, Boise, Idaho, 83720-0036.*~~ ~~*(7-1-98)*~~

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. (10-1-06)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (10-1-06)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (10-1-06)T

04. Telephone. (208) 334-5500. (10-1-06)T

05. Internet Website Address. The website address is: "http://www.healthandwelfare.idaho.gov." (10-1-06)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUEST.

01. Confidentiality of Records. Information received by the Department is subject to the provisions of IDAPA 16.05.01, "Use and Disclosure of Department Records." (10-1-06)T

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (10-1-06)T

00~~*6*~~7. ~~*-- 009.*~~ (RESERVED).

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse or Misconduct." (10-1-06)T

009. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

251. WORK INCENTIVE TABLE.
Work Incentive Table 251 is used in the calculation of the grant amount for families with earned income.

WORK INCENTIVE TABLE 251	
Number of Family Members	**Monthly Amount**
1	$~~304~~ 309
2	$~~304~~ 309
3	$~~382~~ 389
4	$~~459~~ 469
5	$~~537~~ 547
6	$~~614~~ 628
7	$~~692~~ 708
8	$~~769~~ 787
9	$~~847~~ 867
10	$~~925~~ 947
Over 10 Persons	Add $~~78~~ 80 Each

~~(4-5-00)~~(10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

302. ADVANCE NOTIFICATION NOT REQUIRED.
Notification must be provided by the date of the action, but advance notification is not required when a condition listed in Subsections 302.01 through 302.0~~6~~7 exists. ~~(7-1-98)~~(10-1-06)T

01. Family Request. The family requests closure of the grant in writing. (7-1-98)

02. Family Member in Institution. A family member is admitted or committed to an

institution. (7-1-98)

03. Family's Address Unknown. The family's whereabouts are unknown and Department mail is returned showing no known forwarding address. (7-1-98)

04. TANF Received in Another State. A family member is receiving TANF in another state. (7-1-98)

05. Child Removed. A child family member is removed from the home due to a judicial determination. (7-1-98)

06. Intentional Program Violation (IPV). An IPV disqualification begins the first month after the month the member receives written notice of disqualification. (7-1-98)

07. Failure to Comply with Personal Responsibility Contract. A participant fails to comply with activities agreed to in the participant's Personal Responsibility Contract. (10-1-06)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0603 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 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 56-250 through 56-257, 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 notice for the repeal of IDAPA 16.03.09, "Rules Governing the Medical Assistance Program" was published in the August 2, 2006, Idaho Administrative Bulletin, Vol. 06-8, page 137. The rewritten chapter IDAPA 16.03.09, "Medicaid Basic Plan Benefits," published simultaneously under Docket No. 16-0309-0604.**

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Pam Mason at (208) 364-1863.

DATED this 6th day of October, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2006.

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 Sections 56-202(b), 56-203(g), and 56-250 through 56-257, Idaho Code. These rule changes are being made to bring this chapter of rules into compliance with HB 776 (2006) - "Medicaid Modernization and Simplification Act," also, HB 663, HCR 48, HCR 51, and SB 1318 (all passed by the 2006 Legislature).

DEPARTMENT OF HEALTH & WELFARE ***Docket No. 16-0309-0603***
Rules Governing the Medical Assistance Program ***PENDING RULE***

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

Date:	**Wednesday, August 16, 2006**	**Thursday, August 17, 2006**	**Tuesday, August 22, 2006**
Time:	**7:00 p.m.**	**7:00 p.m.**	**7:00 p.m.**
Place:	**Idaho Falls Public Library** **457 Broadway** **Idaho Falls, ID** **Phone: (208) 612-8455**	**Coeur d'Alene Inn** **Hayden Conference Room** **506 W Appleway Ave.** **Coeur d'Alene, ID**	**DHW - Region IV Office** **1720 Westgate Dr.** **Suite D, Room 119** **Boise, 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 nontechnical explanation of the substance and purpose of the proposed rulemaking: This entire chapter of rules is being repealed. The text of the rewritten chapter IDAPA 16.03.09, "Medicaid Basic Plan Benefits," appears under Docket No. 16-0309-0604 that is being published simultaneously with this docket and has the same effective date.

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

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes to rule are being made to implement legislation passed during the 2006 legislative session.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Pam Mason at (208) 364-1863.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, August 23, 2006.

DATED this 30th day of June, 2006.

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 16.03.09 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0604 (CHAPTER REWRITE)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: **The effective dates of the amendments to the temporary rule are July 1, 2006, December 1, 2006, and January 1, 2007.** This pending rule has been adopted by the agency and is now pending review by the 2007 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), 56-203(g), and 56-250 through 56-257, Idaho Code. These rule changes are being made to bring this chapter of rules into compliance with HB 776 (2006) - "Idaho Medicaid Simplification Act," also, HB 663, HCR 48, HCR 51, and SB 1318 (all passed by the 2006 Legislature).

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the 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 following is an overview of amendments made to the pending rule, based on input received during the public comment period:

1. **Updated the references to the Durable Medical Equipment (DME) Supplier Manual in the Incorporation by Reference section and in the DME section.**
2. **Added definitions inadvertently omitted when temporary rules were published in August and clarified several existing definitions;**
3. **Clarified when individuals may provide services on a provisional basis when a criminal history check is required;**
4. **Clarified descriptions of some accounting procedures so as to better reflect practices that have long been in effect;**
5. **Moved the sections regarding the handling of overpayments and underpayments to providers into their own section and clarified the specific provider types to which these provisions apply.**
6. **Deleted obsolete descriptions of "principal year" and clarified how a "principal year" is reckoned;**
7. **Reorganized portions of the rule text, especially the Sections related to Mental Health Clinic services;**
8. **Made corrections to rule citations;**
9. **Added a more detailed description of Preventive Health Assistance (PHA) and and clarified how PHA premiums work;**
10. **Clarified and reorganized the section related to the return of unused prescription**

drugs.

11. **Clarified the requirements for physician recertification of the medical necessity of physical therapy.**
12. **Clarified the prior authorization requirements for services under Early Periodic Screening, Diagnosis, and Treatment (EPSDT).**
13. **Pursuant to Section 67-5228, Idaho Code, made typographical, transcriptional, and/or clerical corrections to the rule being published with this Notice of Rulemaking.**

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 that have been made to the pending rule. Only the sections that have changes from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the August 2, 2006, Idaho Administrative Bulletin, Vol. 06-8, pages 138 through 284.

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

The fiscal impact for SFY 2007 is identified in bills passed by the 2006 Legislature.

1. **HB 663 (2006) projected new costs of $1,125,575 to the General Fund for prevention services and health risk assessments.**
2. **HCR 48 (2006) projected a savings of $3,000,000 to the General Fund through the elimination of partial care services and the reduction of mental health benefits for low-income adults and children without serious mental illness.**
3. **HCR 51 (2006) projected a savings of $189,000 to the General Fund from the implementation of selective contracting.**

New costs as appropriated in the 2007 Budget - $1,944,500 for increased reimbursement for "well child" checks and to pay for provider performance initiatives.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Leslie Clement at (208) 364-1804.

DATED this 14th day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: **The effective dates of the temporary rule are April 7, 2005 and July 1, 2006.**

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 Sections 56-202(b), 56-203(g), and 56-250 through 56-257, Idaho Code. These rule changes are being made to bring this chapter of rules into compliance with HB 776 (2006) - "Medicaid Modernization and Simplification Act," also, HB 663, HCR 48, HCR 51, and SB 1318 (all passed by the 2006 Legislature).

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

Date:	**Wednesday, August 16, 2006**	**Thursday, August 17, 2006**	**Tuesday, August 22, 2006**
Time:	**7:00 p.m.**	**7:00 p.m.**	**7:00 p.m.**
Place:	**Idaho Falls Public Library** **457 Broadway** **Idaho Falls, ID** **Phone: (208) 612-8455**	**Coeur d'Alene Inn** **Hayden Conference Room** **506 W Appleway Ave.** **Coeur d'Alene, ID**	**DHW - Region IV Office** **1720 Westgate Dr.** **Suite D, Room 119** **Boise, 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 nontechnical explanation of the substance and purpose of the proposed rulemaking:**

This chapter of rules has been rewritten to support implementation of the Medicaid Modernization and Simplification Act, HB 776, approved by the 2006 Legislature. This legislation authorized the Idaho Medicaid program to be restructured in order to achieve better health outcomes for participants and to help slow the rate of growth in Medicaid costs. This chapter has also been rewritten to support implementation of HB 663, HCR 48, HCR 51, and SB 1318, passed by the 2006 Legislature.

The primary purpose of these rule changes is to establish the framework that will support on-going Medicaid modernization efforts. To clearly reflect Idaho's Value-based Medicaid Reform, the Medicaid program has been changed in order to provide three distinct benefit packages, each supporting a distinct population with specific health care needs. This chapter of rule has been rewritten as the benefit package known as the "Medicaid Basic Plan," which covers low-income children and working age adults who do not have special health care needs.

In the course of reorganizing the rules to support the new Medicaid structure, the text has been put into standardized format. Where appropriate, each benefit described has sections specific to:

- **definitions**
- **participant eligibility requirements, rights and responsibilities**
- **coverage requirements and limitations**
- **procedural requirements**
- **provider qualifications and duties, and**
- **reimbursement methodologies and quality assurance activities.**

This chapter contains the following changes required pursuant to the enabling legislation cited above:

- **addition of the Health Questionnaire (to identify health needs)**

- **coverage for adult physicals (to promote prevention and wellness)**
- **addition of Preventive Health Assistance benefit (wellness for participants who want assistance with losing weight or to quit smoking)**
- **modification of mental health benefits to match health needs**
- **addition of option for selective contracting**

This chapter also reflects the following changes:

- **removes out-dated cost-sharing requirements in the Health Care for Certain Disabled Children (Katie Beckett) program (pursuant to legislative audit finding)**
- **adds a requirement for certain transportation providers to have criminal history checks (pursuant to legislative audit finding)**
- **incorporates changes in federal requirements regarding school-based services coverage limits and the financial transaction process (existing policy work)**

This chapter contains some provider reimbursement rules that were formerly located in IDAPA 16.03.10, "Medicaid Provider Reimbursement." That chapter of rules has also been rewritten to support another one of the distinct benefit packages, the "Medicaid Enhanced Plan." Benefits described in the new chapter, "Medicaid Enhanced Plan Benefits," are only available to participants who are disabled or who have special health care needs. Rules related to enforcement (e.g., Fraud/SURS) do not reside in this rewritten chapter, but have been moved into the new chapter IDAPA 16.05.07, entitled "Investigation and Enforcement of Fraud, Abuse, and Misconduct," being published simultaneously with this docket under Docket No. 16-0507-0601.

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

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

The fiscal impact for SFY 2007 is identified in bills passed by the 2006 Legislature.

1. **HB 663 (2006) projected new costs of $1,125,575 to the General Fund for prevention services and health risk assessments.**
2. **HCR 48 (2006) projected a savings of $3,000,000 to the General Fund through the elimination of partial care services and the reduction of mental health benefits for low-income adults and children without serious mental illness.**
3. **HCR 51 (2006) projected a savings of $189,000 to the General Fund from the implementation of selective contracting.**

New costs as appropriated in the 2007 Budget - $1,944,500 for increased reimbursement for "well child" checks and to pay for provider performance initiatives.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes to rule are being made to implement legislation passed during the 2006 legislative session.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN

COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Pam Mason at (208) 364-1863.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, August 23, 2006.

DATED this 29th day of June, 2006.

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

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16
TITLE 03
CHAPTER 09

16.03.09 - MEDICAID BASIC PLAN BENEFITS

000. LEGAL AUTHORITY.
~~*Section 56-202b, Idaho Code, enables the Department of Health and Welfare to promulgate public assistance rules. Section 56-203(g), Idaho Code, empowers the Department to define persons entitled to medical assistance. Section 56-203(i), Idaho code, identifies the amount, duration, and scope of care and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. Sections 56-253 through 56-255, Idaho Code, establish minimum standards that enable these rules. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for inpatient services. Provider reimbursement under Title XIX and Title XXI will be in accordance with these rules as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2, that are incorporated by reference in Section 004 of these rules. The provisions apply unless contradicted by these rules.*~~ ~~*(7-1-06)T*~~

01. ***Rulemaking Authority****. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), Idaho Code.* *(7-1-06)T*

02. ***General Administrative Authority****. Titles XIX and XXI of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section*

56-202, Idaho Code. *(7-1-06)T*

03. Administration of the Medical Assistance Program. *(7-1-06)T*

a. *Section 56-203(g), Idaho Code, empowers the Department to define persons entitled to medical assistance.* *(7-1-06)T*

b. *Section 56-203(i), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program.* *(7-1-06)T*

c. *Sections 56-250 through 56-257, Idaho Code, establish minimum standards that enable these rules.* *(7-1-06)T*

04. Fiscal Administration. *(7-1-06)T*

a. *Fiscal administration of these rules is authorized by Titles XIX and XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated in Section 004 of these rules, apply unless otherwise provided for in these rules.* *(7-1-06)T*

b. *Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers.* *(7-1-06)T*

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (7-1-06)T

02. Scope. This chapter of rules contains the general provisions regarding the administration of the Medical Assistance Program. All goods and services not specifically included in this chapter are excluded from coverage under the Medicaid Basic Plan. A guide to covered services is found under Section 399 of these rules. These rules also contain requirements for provider procurement and provider reimbursement. (7-1-06)T

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection at the location identified under Subsection 005.03 of these rules and in accordance with Section 006 of these rules. (7-1-06)T

003. ADMINISTRATIVE APPEALS.
Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-06)T

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: (7-1-06)T

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations internet site at http://www.access.gpo.gov/nara/cfr/cfr-table-search.html. (7-1-06)T

***02. American Academy of Pediatrics (AAP) Periodicity Schedule**. This document is available on the internet at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf. The schedule is also available at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (7-1-06)T*

***03. CDC Child and Teen BMI Calculator**. The Centers for Disease Control (CDC) Child and Teen Body Mass Index (BMI) Calculator is available on the internet at: http://www.cdc.gov/nccdphp/dnpa/bmi/index.htm. The Calculator is also available through the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (7-1-06)T*

0~~2~~4. CDT - 2005. Current Dental Terminology, Fifth Edition. CDT - 2005. Current Dental Terminology, Fifth Edition, is available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60611-2678, or may be ordered online at http://www.ada.org/prof/resources/topics/cdt/manual.asp. A copy is available for public review at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (7-1-06)T

0~~3~~5. 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. (7-1-06)T

0~~4~~6. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL, 60611. (7-1-06)T

0~~5~~7. 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, 450 West State Street, Boise, Idaho, 83702. (7-1-06)T

0~~6~~8. 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. (7-1-06)T

0~~7~~9. Medicare ~~Region D Durable Medical Equipment Regional Carrier DMERC~~ *Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Jurisdiction D* Supplier Manual ~~April~~ 200~~1~~*7, As Amended*. *Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual.* 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, 451 West State Street, Boise, Idaho, 83702~~. DME MAC Jurisdiction D Supplier Manual is available via the Internet at: www.noridianmedicare.com. ~~(7-1-06)T~~(7-1-06)T

~~08~~10. Physician's Current Procedural Terminology (CPT® Manual). This document may be obtained from the American Medical Association, P.O. Box 10950, Chicago, Illinois 60610, or online at: http://www.ama-assn.org/ama/pub/category/3113.html. ~~(7-1-06)T~~(7-1-06)T

~~09~~11. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available on the CMS internet site at http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterBy DID=99&sortByDID=1&sortOrder=ascending&itemID= CMS021929 and http://www.cms. hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=0&sortBy DID=1&sort Order=ascending&itemID=CMS021935. (7-1-06)T

1~~0~~2. 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. (7-1-06)T

1~~1~~3. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov. (7-1-06)T

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

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (7-1-06)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (7-1-06)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (7-1-06)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (7-1-06)T

05. Internet Website. The Department's internet website is found at http:// www.healthandwelfare.idaho.gov". (7-1-06)T

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

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (7-1-06)T

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (7-1-06)T

007. (RESERVED).

008. AUDIT, INVESTIGATION, AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate, and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." (7-1-06)T

009. MANDATORY CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Criminal history checks are required for certain types of providers under these rules. Providers who are required to have a criminal history check must comply with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." (7-1-06)T

02. Availability to Work or Provide Service. ~~*Certain providers are allowed to provide services after the Department has received the self-declaration and fingerprinting, except when they have disclosed a designated crime listed in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." The criminal history check requirements applicable to each provider type are found in the rules that state the qualifications of these providers.*~~
~~*(7-1-06)T*~~(1-1-07)T

a. *The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized, and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant records.* *(1-1-07)T*

b. *Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department.* *(1-1-07)T*

03. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (7-1-06)T

04. Providers Subject to Criminal History Check Requirements. The following providers must receive a criminal history clearance: (7-1-06)T

a. Mental Health Clinics. The criminal history check requirements applicable to mental health clinic staff are found in Subsection 714.0~~6~~5 of these rules. ~~(7-1-06)T~~(7-1-06)T

b. Commercial Non-Emergency Transportation Providers. The criminal history check requirements applicable to commercial non-emergency transportation providers are found in Section 874 of these rules. (10-1-06)T

010. DEFINITIONS -- A THROUGH H.
For the purposes of these rules, thee following terms are used as defined below: (7-1-06)T

01. AABD. Aid to the Aged, Blind, and Disabled. (7-1-06)T

02. 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. (7-1-06)T

***03. Amortization**. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (7-1-06)T*

0~~3~~4. 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. (7-1-06)T

0~~4~~5. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. (7-1-06)T

0~~5~~6. Auditor. The individual or entity designated by the Department to conduct the audit of a provider's records. (7-1-06)T

0~~6~~7. Audit Reports. (7-1-06)T

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (7-1-06)T

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (7-1-06)T

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (7-1-06)T

***08. Bad Debts**. Amounts due to provider as a result of services rendered, but which are*

considered uncollectible. *(7-1-06)T*

0~~7~~9. **Basic Plan**. The medical assistance benefits included under this chapter of rules. (7-1-06)T

~~08~~10. **Buy-In Coverage**. The amount the State pays for Part B of Title XVIII of the Social Security Act on behalf of the participant. (7-1-06)T

~~09~~11. **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. (7-1-06)T

1~~0~~2. **Claim**. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (7-1-06)T

1~~1~~3. **CFR**. Code of Federal Regulations. (7-1-06)T

14. ***Clinical Nurse Specialist****. A licensed professional nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing."* *(7-1-06)T*

1~~2~~5. **CMS**. Centers for Medicare and Medicaid Services. (7-1-06)T

1~~3~~6. **Collateral Contact**. Contact 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. (7-1-06)T

17. ***Co-Payment****. The amount a participant is required to pay to the provider for specified services.* *(7-1-06)T*

1~~4~~8. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (7-1-06)T

1~~5~~9. **Customary Charges**. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt as described in Chapter 3, Sections 310 and 312, PRM. (7-1-06)T

~~16~~20. **Department**. The Idaho Department of Health and Welfare ~~(IDHW)~~ or a person authorized to act on behalf of the Department. ~~(7-1-06)T~~(7-1-06)T

~~17~~21. **Director**. The Director of the Idaho Department of Health and Welfare or his

designee. (7-1-06)T

~~18~~22. **Dual Eligibles**. Medicaid participants who are also eligible for Medicare. (7-1-06)T

~~19~~23. **Durable Medical Equipment (DME)**. Equipment other than prosthetics or orthotics that 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 medical assistance participant. (7-1-06)T

2~~0~~4. **Emergency Medical Condition**. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (7-1-06)T

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (7-1-06)T

b. Serious impairment to bodily functions. (7-1-06)T

c. Serious dysfunction of any bodily organ or part. (7-1-06)T

2~~1~~5. **EPSDT**. Early and Periodic Screening, Diagnosis, and Treatment. (7-1-06)T

2~~2~~6. **Facility**. Facility refers to a hospital, nursing facility, or ~~ICF/MR~~ *intermediate care facility for persons with mental retardation*. ~~(7-1-06)T~~(7-1-06)T

2~~3~~7. **Federally Qualified Health Center (FQHC)**. An entity that meets the requirements of 42 U.S.C Section 1395x(aa)(4). The FQHC may be located in either a rural or urban area designated as a shortage area or in an area that has a medically underserved population. (7-1-06)T

2~~4~~8. **Fiscal Year**. An accounting period that consists of twelve (12) consecutive months. (7-1-06)T

2~~5~~9. **Forced Sale**. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ~~transfer of~~ ownership *transfer* to an existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. ~~(7-1-06)T~~(7-1-06)T

~~26~~30. **Healthy Connections**. The primary care case management model of managed care under Idaho Medicaid. (7-1-06)T

~~27~~31. **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, "Rules for Home Health Agencies." (7-1-06)T

~~28~~.32 **Hospital**. A hospital as defined in Section 39-1301, Idaho Code. (7-1-06)T

~~29~~33. **Hospital-Based Facility**. A nursing facility that is owned, managed, or operated by, or is otherwise a part of a licensed hospital. (7-1-06)T

011. DEFINITIONS -- I THROUGH O.
For the purposes of these rules, the following terms are used as defined below: (7-1-06)T

01. ICF/MR. Intermediate Care Facility for Persons with Mental Retardation. An ICF/MR is an entity licensed as an ICF/MR and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (7-1-06)T

02. 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. (7-1-06)T

03. Intermediary. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (7-1-06)T

04. 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. (7-1-06)T

05. 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. (7-1-06)T

06. 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. (7-1-06)T

07. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (7-1-06)T

08. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (7-1-06)T

09. Lock-In Program. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (7-1-06)T

10. 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 a period of fourteen (14) continuous days or less. (7-1-06)T

11. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (7-1-06)T

12. Medicaid. Idaho's Medical Assistance Program. (7-1-06)T

13. Medicaid-Related Ancillary Costs. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. (7-1-06)T

14. Medical Necessity (Medically Necessary). A service is medically necessary if: (7-1-06)T

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the ~~*individual*~~ *participant* that endanger life, cause pain, or cause functionally significant deformity or malfunction; and ~~*(7-1-06)T*~~(7-1-06)T

b. There is no other equally effective course of treatment available or suitable for the ~~*individual*~~ *participant* requesting the service which is more conservative or substantially less costly. ~~*(7-1-06)T*~~(7-1-06)T

c. Medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. ~~*(7-1-06)T*~~(7-1-06)T

15. Medical Supplies. Items excluding drugs, 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. (7-1-06)T

16. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (7-1-06)T

17. Nonambulatory. Unable to walk without assistance. (7-1-06)T

18. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (7-1-06)T

19. Nurse Midwife (NM). A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse midwife under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-06)T

20. Nurse Practitioner (NP). A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-06)T

21. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an ~~*entitity*~~ *entity* licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. ~~*(7-1-06)T*~~(7-1-06)T

22. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (7-1-06)T

23. Outpatient 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 *inpatient* hospital care. ~~*(7-1-06)T*~~(7-1-06)T

24. 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. (7-1-06)T

25. 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. (7-1-06)T

012. DEFINITIONS -- P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (7-1-06)T

01. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (7-1-06)T

02. Patient. The person undergoing treatment or receiving services from a provider. (7-1-06)T

03. 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. (7-1-06)T

04. Physician Assistant (PA). A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." (7-1-06)T

05. Plan of Care. A written description of medical, remedial, 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. (7-1-06)T

06. Private Rate. Rate most frequently charged to private patients for a service or item. (7-1-06)T

07. PRM. Provider Reimbursement Manual. (7-1-06)T

08. Property. The homestead and all personal and real property in which the participant has a legal interest. (7-1-06)T

09. 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: (7-1-06)T

a. Artificially replace a missing portion of the body; or (7-1-06)T

b. Prevent or correct physical deformities or malfunctions; or (7-1-06)T

c. Support a weak or deformed portion of the body. (7-1-06)T

d. Computerized communication devices are not included in this definition of a prosthetic device. (7-1-06)T

10. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and who has entered into a written provider agreement with the Department in accordance with Section 205 of these rules. (7-1-06)T

11. Provider Agreement. A written agreement between the provider and the Department, entered into in accordance with Section 205 of these rules. (7-1-06)T

12. Provider Reimbursement Manual (PRM). A federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated by reference in Section 004 of these rules. (7-1-06)T

13. Prudent Layperson. A person who possesses an average knowledge of health and medicine. (7-1-06)T

14. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-06)T

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

registered with the Bureau of Occupational Licenses. (7-1-06)T

16. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (7-1-06)T

17. Quality Improvement Organization (QIO). An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. A QIO is formerly known as a Peer Review Organization (PRO). (7-1-06)T

18. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. (7-1-06)T

19. R.N. Registered Nurse, which in the State of Idaho is known as a Licensed Professional Nurse. (7-1-06)T

20. Rural Health Clinic (RHC). An outpatient entity that meets the requirements of 42 U.S.C Section 1395x(aa)(2). It is primarily engaged in furnishing physicians and other medical and health services in rural, federally-defined, medically underserved areas, or designated health professional shortage areas. (7-1-06)T

21. Rural Hospital-Based Nursing Facilities. Hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (7-1-06)T

22. Social Security Act. 42 U.S.C 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons who meet certain criteria. (7-1-06)T

23. Speech/Language Pathology and Audiology Services. Diagnostic, screening, preventative, or corrective services provided by a licensed speech pathologist or audiologist, unless exempted from licensure under Title 54, Chapter 29, Idaho Code, 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. (7-1-06)T

24. State Plan. The contract between the state and federal government under 42 U.S.C. Section 1396a(a). (7-1-06)T

25. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (7-1-06)T

26. Title XVIII. Title XVIII of the Social Securty Act, known as Medicare, for aged, blind, and disabled individuals administered by the federal government. (7-1-06)T

27. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (7-1-06)T

28. **Title XXI**. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (7-1-06)T

29. **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 medical assistance participant. (7-1-06)T

30. **Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (7-1-06)T

013. MEDICAL CARE ADVISORY COMMITTEE.
The Director of the Department will appoint a Medical Care Advisory Committee to advise and counsel on all aspects of health and medical services. (7-1-06)T

01. **Membership**. The Medical Care Advisory Committee will include, but not be limited to, the following: (7-1-06)T

a. Licensed physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; and (7-1-06)T

b. Members of consumer groups, including medical assistance participants and consumer organizations. (7-1-06)T

02. **Organization**. The Medical Care Advisory Committee will: (7-1-06)T

a. Consist of not more than twenty-two (22) members; and (7-1-06)T

b. Be appointed by the Director to the Medical Care Advisory Committee to serve three (3) year terms, whose terms are to overlap; and (7-1-06)T

c. Elect a chairman and a vice-chairman to serve a two (2) year term; and (7-1-06)T

d. Meet at least quarterly; and (7-1-06)T

e. Submit a report of its activities and recommendations to the Director at least once each year. (7-1-06)T

03. **Policy Function**. The Medical Care Advisory Committee must be given opportunity to participate in medical assistance policy development and program administration. (7-1-06)T

04. **Staff Assistance**. The Medical Care Advisory Committee must be provided staff assistance from within the Department and independent technical assistance as needed to enable them to make effective recommendations, and will be provided with travel and per diem costs, where necessary. (7-1-06)T

014. -- 099. (RESERVED).

GENERAL PARTICIPANT PROVISIONs
(Sections 100 Through 199)

100. ELIGIBILITY FOR MEDICAL ASSISTANCE.
Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," are applicable in determining eligibility for medical assistance. (7-1-06)T

101. -- 124. (RESERVED).

125. MEDICAL ASSISTANCE PROCEDURES.

01. Issuance of Identification Cards. When a person is determined eligible for medical assistance, the Department will issue a Medicaid identification card to the participant. When requested, the Department will give providers of medical services eligibility information regarding participants so that services may be provided. (7-1-06)T

02. Identification Card Information. An identification card will be issued to each participant and will contain the following information: (7-1-06)T

a. The name of the participant to whom the card was issued; and (7-1-06)T

b. The participant's Medicaid identification number; and (7-1-06)T

c. The card number. (7-1-06)T

03. Information Available for Participants. The following information will be available at each Field Office for use by each medical assistance participant: (7-1-06)T

a. The amount, duration and scope of the available care and services; and (7-1-06)T

b. The manner in which the care and services may be secured; and (7-1-06)T

c. How to use the identification card. (7-1-06)T

126. -- 149. (RESERVED).

150. CHOICE OF PROVIDERS.

01. Service Selection. Each participant may obtain any services available from any participating institution, agency, pharmacy, or practitioner of his choice, unless enrolled in Healthy Connections. 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

Medical Assistance Program, or from setting standards relating to the qualifications of providers of such care. (7-1-06)T

02. Lock-In Option. (7-1-06)T

a. The Department may implement a total or partial lock-in program for any participant found to be misusing the Medical Assistance Program according to provisions in Sections 910 through 918 of these rules. (7-1-06)T

b. In situations where the participant has been restricted to a participant lock-in program, that participant may choose the physician and pharmacy of his choice. The providers chosen by the lock-in participant will be identified in the Department's Eligibility Verification System (EVS). This information will be available to any Medicaid provider who accesses the EVS. (7-1-06)T

151. -- 199. (RESERVED).

GENERAL PROVIDER PROVISIONS
(Sections 200 Through 299)

200. PROVIDER APPLICATION PROCESS.

01. Provider Application. Providers may apply for provider numbers with the Department. Those in-state providers who have previously been assigned a Medicare number may retain that same number. The Department will confirm the status for all applicants with the appropriate licensing board and assign Medicaid provider numbers. (7-1-06)T

02. Denial of Provider Application. The Department must not accept the application of a provider who is suspended from Medicare or Medicaid in another state. (7-1-06)T

201. -- 204. (RESERVED).

205. AGREEMENTS WITH PROVIDERS.

01. In General. The Department will enter into written agreements with each provider or group of providers of supplies or services under the Program. Agreements may contain any terms or conditions deemed appropriate by the Department. Each agreement will contain, among others, the following terms and conditions requiring the provider: (7-1-06)T

a. To retain for a minimum of six (6) years any records necessary for a determination of the services the provider furnishes to participants; and (7-1-06)T

b. To furnish to the Department, the U.S. Department of Health and Human Services, the Fraud Investigation Unit, or the Idaho State Police any information requested regarding payments claimed by the provider for services; and (7-1-06)T

c. To furnish to the Department, the U.S. Department of Health and Human Services,

the Fraud Investigation Unit, or the Idaho State Police, information requested on business transactions as follows: (7-1-06)T

i. Ownership of any subcontractor with whom the provider has had business transactions of more than twenty-five thousand dollars ($25,000) during a twelve (12) month period ending on the date of request; and (7-1-06)T

ii. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five (5) year period ending on the date of request. (7-1-06)T

02. Federal Disclosure Requirements. To comply with the disclosure requirements in 42 CFR 455, Subpart B, each provider, other than an individual practitioner or a group of practitioners, must disclose to the Department: (7-1-06)T

a. The full name and address of each individual who has either direct or indirect ownership interest in the disclosing entity or in any subcontractor of five percent (5%) or more prior to entering into an agreement or at the time of survey and certification; and (7-1-06)T

b. Whether any person named in the disclosure is related to another person named in the disclosure as a spouse, parent, or sibling. (7-1-06)T

03. Termination of Provider Agreements. Provider agreements may be terminated with or without cause. (7-1-06)T

a. The Department may, in its discretion, terminate a provider's agreement for cause based on its conduct or the conduct of its employees or agents, when the provider fails to comply with any term or provision of the provider agreement. Other action may also be taken, based on the conduct of the provider as provided in Section 205 of this chapter of rules, and notice of termination must be given as provided therein. Terminations for cause may be appealed as a contested case in accordance with the IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Ruling." (7-1-06)T

b. Due to the need to respond quickly to state and federal mandates, as well as the changing needs of the State Plan, the Department may terminate provider agreements without cause by giving written notice to the provider as set forth in the agreement. If an agreement does not provide a notice period, the period is twenty-eight (28) days. Terminations without cause may result from, but are not limited to, elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers, or will result from the discretionary act of another regulatory body. (7-1-06)T

04. Denial of Provider Agreement. The Department may deny provider status by refusing a request to enter into a provider agreement, refusing to extend an existing agreement, or refusing to enter into additional agreements with any individual or entity, that: (7-1-06)T

a. Fails to meet the qualifications required by rule or by any applicable licensing

board; (7-1-06)T

b. Has previously been, or was a managing employee, or had an ownership interest, as defined in 42 C.F.R Section 455.101, in any entity which was previously found by the Department to have engaged in fraudulent conduct, or abusive conduct related to the Medicaid program or has demonstrated an inability to comply with the requirements related to the provider status for which application is made, including, but not limited to submitting false claims or violating provisions of any provider agreement; (7-1-06)T

c. Has failed, or was a managing employee, or had an ownership interest, as defined in 42 C.F.R Section 455.101, in any entity that failed to repay the Department for any overpayments, or to repay claims previously found by the Department to have been paid improperly, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law; or (7-1-06)T

d. Employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in Subsections 205.04.a. through 205.04.c., of this rule. (7-1-06)T

206. -- 211. (RESERVED).

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided that each of the following conditions are met: (7-1-06)T

a. The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (7-1-06)T

b. The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf; and (7-1-06)T

c. Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (7-1-06)T

02. Time Limits. The time limit set forth in Subsection 210.01.c. of this rule does not apply with respect to retroactive adjustment payments. (7-1-06)T

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. (7-1-06)T

04. Payment in Full. If a provider accepts Medicaid payment for a covered service,

the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (7-1-06)T

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (7-1-06)T

211. -- 214. (RESERVED).

215. THIRD PARTY LIABILITY.

01. Determining Liability of Third Parties. The Department will take reasonable measures to determine any legal liability of third parties for medical care and services rendered to a participant. (7-1-06)T

02. Third Party Liability as a Current Resource. The Department is to treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. (7-1-06)T

03. Withholding Payment. The Department must not withhold payment on behalf of a participant because of the liability of a third party when such liability, or the amount thereof, cannot be currently established or is not currently available to pay the participant's medical expense. (7-1-06)T

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party when the party's liability is established after reimbursement to the provider is made, and in any other case in which the liability of a third party existed, but was not treated as a current resource, with the exceptions of EPSDT and EPSDT-related services. (7-1-06)T

a. The Department will seek reimbursement from a participant when a participant's liability is established after reimbursement to the provider is made; and (7-1-06)T

b. In any other situation in which the participant has received direct payment from any third party resource and has not forwarded the money to the Department for services or items received. (7-1-06)T

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third party payment, with the exception of absent parent (court ordered) without secondary resources, prenatal, EPSDT and EPSDT-related services before submitting the claim to the Department. If the resource is an absent parent (court ordered) and there are no other viable resources available or if the claims are for prenatal, EPSDT, or EPSDT-related services, the claims will be paid and the resources billed by the Department. (7-1-06)T

06. Accident Determination. When the participant's Medicaid card indicates private insurance and/or when the diagnosis indicates an accident for which private insurance is often carried, the claim will be suspended or denied until it can be determined that there is no other source of payment. (7-1-06)T

07. Third Party Payments in Excess of Medicaid Limits. The Department will not reimburse providers for services provided when the amount received by the provider from the third party payor is equal to or exceeds the level of reimbursement allowed by medical assistance for the services. (7-1-06)T

08. Subrogation of Third Party Liability. In all cases where the Department will be required to pay medical expenses for a participant and that participant is entitled to recover any or all such medical expenses from any third party, the Department will be subrogated to the rights of the participant to the extent of the amount of medical assistance benefits paid by the Department as the result of the occurrence giving rise to the claim against the third party. (7-1-06)T

a. If litigation or a settlement in such a claim is pursued by the medical assistance participant, the participant must notify the Department. (7-1-06)T

b. If the participant recovers funds, either by settlement or judgment, from such a third party, the participant must repay the amount of benefits paid by the Department on his behalf. (7-1-06)T

09. Subrogation of Legal Fees. (7-1-06)T

a. If a medical assistance participant incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept in compromise of its claim, will be reduced by an amount which bears the same relation to the total amount of attorney fees and court costs actually paid by the participant as the amount actually recovered by the Department, exclusive of the reduction for attorney fees and court costs, bears to the total amount paid by the third party to the participant. (7-1-06)T

b. If a settlement or judgment is received by the participant which does not specify portion of the settlement or judgment which is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses incurred by the participant in an amount equal to the expenditure for benefits paid by the Department as a result of the payment or payments to the participant. (7-1-06)T

216. -- 224. (RESERVED).

225. REPORTING TO THE INTERNAL REVENUE SERVICE (IRS).
In accordance with 26 U.S.C 6041, the Department must provide annual information returns to the IRS showing aggregate amounts paid to providers identified by name, address, and social security number or employer identification number. (7-1-06)T

226. -- 229. (RESERVED).

230. GENERAL PAYMENT PROCEDURES.

01. Provided Services. (7-1-06)T

a. Each participant may consult a participating physician or provider of his choice for care and receive covered services by presenting his identification card to the provider, subject to restrictions imposed by a participation in Healthy Connections. (7-1-06)T

b. The provider must obtain the required information by using the Medicaid number on the identification card from the Electronic Verification System and transfer the required information onto the appropriate claim form. Where the Electronic Verification System (EVS) indicates that a participant is enrolled in Healthy Connections, the provider must obtain a referral from the primary care provider. Claims for services provided to participant designated as participating in Healthy Connections by other than the primary care provider, without proper referral, will not be paid. (7-1-06)T

c. Upon providing the care and services to a participant, the provider or his agent must submit a properly completed claim to the Department. (7-1-06)T

d. The Department is to process each claim received and make payment directly to the provider. (7-1-06)T

e. The Department will not supply claim forms. Forms needed to comply with the Department's unique billing requirements are included in Appendix D of the Idaho Medicaid Provider Handbook. (7-1-06)T

02. Individual Provider Reimbursement. The Department will not pay the individual provider more than the lowest of: (7-1-06)T

a. The provider's actual charge for service; or (7-1-06)T

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (7-1-06)T

c. The ~~*Department will pay the lesser of the*~~ Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. ~~*(7-1-06)T*~~(7-1-06)T

03. Services Normally Billed Directly to the Patient. If a provider delivers services and it is customary for the provider to bill patients directly for such services, the provider must complete the appropriate claim form and submit it to the Department. (7-1-06)T

04. Reimbursement for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services which are not included in other Idaho Department of Health and Welfare Rules, but allowed under Idaho's Medical Assistance Program according to the provisions of 42 CFR Section 447.325. (7-1-06)T

05. Review of Records. (7-1-06)T

a. The Department, or its duly authorized agent, the U.S. Department of Health and Human Services, and the Bureau of Audits and Investigations have the right to review pertinent records of providers receiving Medicaid reimbursement for covered services. (7-1-06)T

b. The review of participants' medical and financial records must be conducted for the purposes of determining: (7-1-06)T

i. The necessity for the care; or (7-1-06)T

ii. That treatment was rendered in accordance with accepted medical standards of practice; or (7-1-06)T

iii. That charges were not in excess of the provider's usual and customary rates; or (7-1-06)T

iv. That fraudulent or abusive treatment and billing practices are not taking place. (7-1-06)T

c. Refusal of a provider to permit the Department to review records pertinent to medical assistance will constitute grounds for: (7-1-06)T

i. Withholding payments to the provider until access to the requested information is granted; or (7-1-06)T

ii. Suspending the provider's number. (7-1-06)T

06. Lower of Cost or Charges. Payment to providers, other than public providers furnishing such services free of charge or at nominal charges to the public, is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge or at a nominal charge are reimbursed fair compensation which is the same as reasonable cost. (7-1-06)T

07. Procedures for Medicare Cross-Over Claims. (7-1-06)T

a. If a medical assistance participant is eligible for Medicare, the provider must first bill Medicare for the services rendered to the participant. (7-1-06)T

b. If a provider accepts a Medicare assignment, the Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the provider 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. (7-1-06)T

c. If a provider does not accept a Medicare assignment, a 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. (7-1-06)T

d. For all other services, a 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. (7-1-06)T

***08. Services Reimbursable After the Appeals Process**. Reimbursement for services originally identified by the Department as not medically necessary will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-06)T*

231. HANDLING OF OVERPAYMENTS AND UNDERPAYMENTS FOR SPECIFIED PROVIDERS.

The provisions in Subsections 231.01 and 231.02 of this rule apply only to hospitals, FQHCs, RHCs and Home Health providers. (7-1-06)T

***01. Interest Charges on Overpayments and Underpayments**. The Medicaid program will charge interest on overpayments, and pay interest on underpayments, as follows: (7-1-06)T*

***a.** Interest After Sixty Days of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received the Department reimbursement notice, interest will accrue from the date of receipt of the Department reimbursement notice, and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. (7-1-06)T*

***b.** Waiver of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges. (7-1-06)T*

***c.** Rate of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly. (7-1-06)T*

***d.** Retroactive Adjustment. The balance and interest will be retroactively adjusted to equal the amounts that would have been due based on any changes which occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties will only applied to unpaid amounts and will be subordinated to final interest determinations made in the judicial review process. (7-1-06)T*

***02. Recovery Methods for Overpayments**. One (1) of the following methods will be used for recovery of overpayments: (7-1-06)T*

***a.** Lump Sum Voluntary Repayment. Upon receipt of the notice of program reimbursement, the provider voluntarily refunds, in a lump sum, the entire overpayment to the Department. (7-1-06)T*

***b.** Periodic Voluntary Repayment. The provider must request in writing that recovery*

of the overpayment be made over a period of twelve (12) months or less. The provider must adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested. *(7-1-06)T*

c. *Department Initiated Recovery. The Department will recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receiving the notice.* *(7-1-06)T*

d. *Recovery from Medicare Payments. The Department can request that Medicare payments be withheld in accordance with 42 CFR Section 405.377.* *(7-1-06)T*

23~~1~~2. -- 234. (RESERVED).

235. PATIENT "ADVANCE DIRECTIVES".

01. Provider Participation. Hospitals, nursing facilities, providers of home health care services (home health agencies, federally qualified health clinics, rural health clinics), hospice providers, and personal care R.N. supervisors must: (7-1-06)T

a. Provide all adults receiving medical care written and oral information (the information provided must contain all material found in the Department's approved advance directive form "Your Rights As A Patient To Make Medical Treatment Decisions") which defines their rights under state law to make decisions concerning their medical care. (7-1-06)T

i. The provider must explain that the participant has the right to make decisions regarding their medical care which includes the right to accept or refuse treatment. If the participant has any questions regarding treatment, the facility or agency will notify the physician of those concerns. Their physician can answer any questions they may have about the treatment. (7-1-06)T

ii. The provider will inform the participant of their rights to formulate advance directives, such as "Living Will" and/or "Durable Power of Attorney For Health Care". (7-1-06)T

iii. The provider must comply with Subsection 235.02 of this rule. (7-1-06)T

b. Provide all adults receiving medical care written information on the providers' policies concerning the implementation of the participant's rights regarding "Durable Power of Attorney for Health Care," "Living Will," and the participant's right to accept or refuse medical and surgical treatment. (7-1-06)T

c. Document in the participant's medical record whether the participant has executed an advance directive ("Living Will" and/or "Durable Power of Attorney for Health Care") or, have a copy of the Department's approved advance directive form ("Your Rights as a Patient to Make Medical Treatment Decisions") attached to the patient's medical record which has been completed acknowledging whether the patient/resident has executed an advance directive ("Living Will" and/or "Durable Power of Attorney for Health Care"). (7-1-06)T

d. The provider cannot condition the provision of care or otherwise discriminate against an individual based on whether that participant has executed an "Advance Directive". (7-1-06)T

e. If the provider cannot comply with the patient's "Living Will" and/or "Durable Power of Attorney for Health Care" as a matter of conscience, the provider will assist the participant in transferring to a facility or agency that can comply. (7-1-06)T

f. Provide education to their staff and the community on issues concerning advance directives. (7-1-06)T

02. When "Advance Directives" Must be Given. Hospitals, nursing facilities, providers of home health care (home health agencies, federally qualified health centers, rural health clinics), hospice agencies, and personal care R.N. supervisors, must give information concerning "Advance Directives" to adult participants in the following situations: (7-1-06)T

a. Hospitals must give the information at the time of the participant's admission as an inpatient unless Subsection 235.03 of this rule applies. (7-1-06)T

b. Nursing facilities must give the information at the time of the participant's admission as a resident. (7-1-06)T

c. Home health providers must give the information to the participant in advance of the participant coming under the care of the provider. (7-1-06)T

d. The personal care R.N. supervisors will inform the participant when the R.N. completes the R.N. Assessment and Care Plan. The R.N. supervisor will inform the Qualified Mental Retardation Professional (QMRP) and the personal care attendant of the participants decision regarding "Advance Directives". (7-1-06)T

e. A hospice provider must give information at the time of initial receipt of hospice care by the participant. (7-1-06)T

03. Information Concerning "Advance Directives" at the Time an Incapacitated Individual is Admitted. An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether he has executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with state law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once he is no longer incapacitated. (7-1-06)T

04. Provider Agreement. A "Memorandum of Understanding Regarding Advance Directives" is incorporated within the provider agreement. By signing the Medicaid provider agreement, the provider is not excused from its obligation regarding advance directives to the general public per Section 1902(a) of the Social Security Act, as amended by Section 4751 of OBRA 1990. (7-1-06)T

236. -- 239. (RESERVED).

240. QUALIFIED PROVIDERS OF PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN.
The Department will enter into provider agreements allowing presumptive eligibility determination with providers who meet the qualifications of Section 1920(b)(2)(d) of the Social Security Act, and who employ individuals who have completed a course of training supplied by the Department. (7-1-06)T

241. -- 24~~9~~4. (RESERVED).

245. PROVIDERS OF SCHOOL-BASED SERVICES.
Only school districts, charter schools, and the Idaho Infant Toddler Program can be reimbursed for the services described in Sections 850 through 856 of these rules. (7-1-06)T

246. -- 249. (RESERVED).

250. SELECTIVE CONTRACTING.
The Department may contract with a limited number of providers of certain Medicaid products and services, including: dental services, eyeglasses, transportation, and some medical supplies. (7-1-06)T

251. -- 299. (RESERVED).

GENERAL REIMBURSEMENT PROVISIONS FOR INSTITUTIONAL PROVIDERS
(Sections 300 Through 389)

300. COST REPORTING.
The provider's Medicaid cost report must be filed using the Department designated reporting forms, unless the Department has approved an exception. The request to use alternate forms must be sent to the Department in writing, with samples attached, a minimum of ninety (90) days prior to the due date for the cost report. The request for approval of alternate forms cannot be used as a reason for late filing. (7-1-06)T

301. -- 304. (RESERVED).

305. REIMBURSEMENT SYSTEM AUDITS.

01. Scope of Reimbursement System Audits. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records: (7-1-06)T

a. Cost verification of actual costs for providing goods and services; (7-1-06)T

b. Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; (7-1-06)T

c. Effectiveness of the service to achieve desired results or benefits; and (7-1-06)T

d. Reimbursement rates or settlement calculated under this chapter. (7-1-06)T

02. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." (7-1-06)T

306. -- 329. (RESERVED).

330. PROVIDER'S RESPONSIBILITY TO MAINTAIN RECORDS.
The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Section 305 of these rules. (7-1-06)T

01. Expenditure Documentation. Documentation of expenditures must include the amount, date, purpose, payee, and the invoice or other verifiable evidence supporting the expenditure. (7-1-06)T

02. Cost Allocation Process. Costs such as depreciation or amortization of assets and indirect expenses are allocated to activities or functions based on the original identity of the costs. Documentation to support basis for allocation must be available for verification. *The assets referred to in this Section of rule are economic resources of the provider recognized and measured in conformity with generally accepted accounting principles.* ~~(7-1-06)T~~(7-1-06)T

03. Revenue Documentation. Documentation of revenues must include the amount, date, purpose, and source of the revenue. (7-1-06)T

04. Availability of Records. Records must be available for and subject to audit by the auditor, with or without prior notice, during any working day between the hours of 8:00 a.m. and 5:00 p.m. at the provider's principal place of business in the state of Idaho. (7-1-06)T

a. The provider is given the opportunity to provide documentation before the interim final audit report is issued. (7-1-06)T

b. The provider is not allowed to submit additional documentation in support of cost items after the issuance of the interim final audit report. (7-1-06)T

05. Retention of Records. Records required in Subsections 330.01 through 330.03 of this rule must be retained by the provider for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for the goods or services. (7-1-06)T

331. -- 339. (RESERVED).

340. DRAFT AUDIT REPORT.
Following completion of the audit field work and before issuing the interim final audit report to

the Department, the auditor will issue a draft audit report and forward a copy to the provider for review and comment. (7-1-06)T

01. Review Period. The provider will have a period of sixty (60) days, beginning on the date of transmittal, to review and provide additional comments or evidence pertaining to the draft audit report. The review period may be extended when the provider: (7-1-06)T

a. Requests an extension prior to the expiration of the original review period; and (7-1-06)T

b. Clearly demonstrates the need for additional time to properly respond. (7-1-06)T

02. Evaluation of Provider's Response. The auditor will evaluate the provider's response to the draft audit report and will delete, modify, or reaffirm the original findings, as deemed appropriate, in preparing the interim final audit report. (7-1-06)T

341. FINAL AUDIT REPORT.
The auditor will incorporate the provider's response and an analysis of the response into the interim final report as appendices and transmit it to the Department. The Department will issue a final audit report and a notice of program reimbursement, if applicable, that sets forth settlement amounts due to the Department or the provider. The final audit report and notice of program reimbursement, if applicable, will take into account the findings made in the interim final audit report and the response of the provider to the draft audit report (7-1-06)T

342. -- 349. (RESERVED).

350. CRITERIA FOR PARTICIPATION IN THE MEDICAID PROGRAM.

01. Application for Participation and Reimbursement. Prior to participation in the Medicaid Program, the Department must certify a facility for participation in the Program. Their recommendations are forwarded to the Division of Welfare, Division of Medicaid or its successor organization, for approval. The Division of Medicaid or its successor organization issues a provider number to the facility which becomes the primary provider identification number. The Division of Medicaid or its successor organization will need to establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued. (7-1-06)T

02. Reimbursement. The reimbursement mechanism for payment to providers that Medicaid reimburses under a cost-based methodology under Sections 300 through 389 of these rules. The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate. (7-1-06)T

351. -- 359. (RESERVED).

360. RELATED PARTY TRANSACTIONS.

01. Principle. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc.,

are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (7-1-06)T

02. Cost Allowability - Regulation. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al., and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. (7-1-06)T

361. APPLICATION.

01. Determination of Common Ownership or Control in the Provider Organization and Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (7-1-06)T

a. Common Ownership Rule. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. (7-1-06)T

b. Control Rule. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. (7-1-06)T

02. Cost to Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. (7-1-06)T

03. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the Program. (7-1-06)T

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See Chapters 2, 10, and 12, PRM, for specifics. (7-1-06)T

362. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.
An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary: (7-1-06)T

01. Supplying Organization. That the supplying organization is a bona fide separate organization; (7-1-06)T

02. Nonexclusive Relationship. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. (7-1-06)T

03. Lease or Rentals of Hospital. The exception is not applicable to sales, lease or

rentals of hospitals. These transactions would not meet the requirement that there be an open, competitive market for the facilities furnished as described in Sections 1008 and 1012, PRM. (7-1-06)T

a. Rentals. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (7-1-06)T

b. Purchases. When a facility is purchased from a related entity, the purchaser's depreciable basis must not exceed the seller's net book value as described in Section 1005, PRM. (7-1-06)T

363. -- 389. (RESERVED).

EXCLUDED SERVICES
(Section 390)

390. SERVICES, TREATMENTS, AND PROCEDURES NOT COVERED BY MEDICAL ASSISTANCE.
The following services, treatments, and procedures are not covered for payment by the Medical Assistance Program: (4-7-05)T

01. Service Categories Not Covered. The following service categories are not covered for payment by the Medical Assistance Program: (4-7-05)T

a. Acupuncture services; (4-7-05)T

b. Naturopathic services; (4-7-05)T

c. Bio-feedback therapy; ~~*and*~~ ~~*(7-1-06)T*~~(7-1-06)T

d. *Group exercise therapy;* *(7-1-06)T*

e. *Group hydrotherapy; and* *(7-1-06)T*

~~*d*~~***f.*** Fertility-related services, including testing. (4-7-05)T

02. Types of Treatments and Procedures Not Covered. The costs of physician and hospital services for the following types of treatments and procedures are not covered for payment by the Medical Assistance Program: (4-7-05)T

a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; (4-7-05)T

b. Cosmetic surgery, excluding reconstructive surgery that has prior approval by the Department; (4-7-05)T

c. Acupuncture; (4-7-05)T

d. Bio-feedback therapy; (4-7-05)T

e. Laetrile therapy; (4-7-05)T

f. Procedures and testing for the inducement of fertility. This includes, but is not limited to, artificial inseminations, consultations, counseling, office exams, tuboplasties, and vasovasostomies; (4-7-05)T

g. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program or major commercial carriers; (4-7-05)T

h. Drugs supplied to patients for self-administration other than those allowed under the conditions of Section 662 of these rules; (4-7-05)T

i. Services provided by psychologists and social workers who are employees or contract agents of a physician, or a physician's group practice association except for psychological testing on the order of the physician; (4-7-05)T

j. The treatment of complications, consequences, or repair of any medical procedure where the original procedure was not covered by the Medical Assistance Program, unless the resultant condition is life-threatening as determined by the Department; (4-7-05)T

k. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service; (4-7-05)T

l. Eye exercise therapy; or (4-7-05)T

m. Surgical procedures on the cornea for myopia. (7-1-06)T

03. Experimental Treatments or Procedures. Treatments and procedures used solely to gain further evidence or knowledge or to test the usefulness of a drug or type of therapy are not covered for payment by the Medical Assistance Program. This includes both the treatment or procedure itself, and the costs for all follow-up medical treatment directly associated with such a procedure. Treatments and procedures deemed experimental are not covered for payment by the Medical Assistance Program under the following circumstances: (4-7-05)T

a. The treatment or procedure is in Phase I clinical trials in which the study drug or treatment is given to a small group of people for the first time to evaluate its safety, determine a safe dosage range, and identify side effects; (4-7-05)T

b. There is inadequate available clinical or pre-clinical data to provide a reasonable expectation that the trial treatment or procedure will be at least as effective as non-investigational therapy; or (4-7-05)T

c. Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. (4-7-05)T

391. -- 398. (RESERVED).

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.
Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits described in this chapter of rules. Those individuals eligible for *services under IDAPA 16.03.10, "*Medicaid Enhanced Plan Benefits*,"* ~~*under*~~ are also eligible for the services covered under this chapter of rules*, unless specifically exempted*. ~~*(7-1-06)T*~~(7-1-06)T

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 447 of these rules. (7-1-06)T

a. Inpatient Hospital Services are described in Sections 400 through 406. (7-1-06)T

b. Outpatient Hospital Services are described in Sections 410 through 416. (7-1-06)T

c. Reconstructive Surgery services are described in Sections 420 through 426. (7-1-06)T

d. Surgical procedures for weight loss are described in Sections 430 through 436. (7-1-06)T

e. Investigational procedures or treatments are described in Sections 440 through 446. (7-1-06)T

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 456 of these rules. (7-1-06)T

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 516 of these rules. (7-1-06)T

a. Physician services are described in Sections 500 through 506. (7-1-06)T

b. Abortion procedures are described in Sections 510 through 516. (7-1-06)T

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 556 of these rules. (7-1-06)T

a. Midlevel practitioner services are described in Sections 520 through 526. (7-1-06)T

b. Chiropractic services are described in Sections 530 through 536. (7-1-06)T

c. Podiatrist services are described in Sections 540 through 546. (7-1-06)T

d. Optometrist services are described in Sections 550 through 556. (7-1-06)T

05. Primary Care Case Management. Primary Care Case Management services are described in Sections 560 through 56**6** of these rules**.** (7-1-06)T

06. Prevention Services. The range of prevention services covered is described in Sections 570 through 646 of these rules. (7-1-06)T

a. Health Risk Assessment services are described in Sections 570 through 576. (7-1-06)T

b. Child wellness services are described in Sections 580 through 586. (7-1-06)T

c. Adult physical services are described in Sections 590 through 596. (7-1-06)T

d. Screening mammography services are described in Sections 600 through 606. (7-1-06)T

e. Diagnostic Screening Clinic services are described in Sections 610 through 616. (7-1-06)T

f. Personal Health Account services are described in Sections 620 through 626. (7-1-06)T

g. Nutritional services are described in Sections 630 through 636. (7-1-06)T

h. Diabetes Education and Training services are described in Sections 640 through 646. (7-1-06)T

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 656 of these rules. (7-1-06)T

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 666 of these rules. (7-1-06)T

09. Family Planning. Family planning services are described in Sections 680 through 686 of these rules. (7-1-06)T

10. Mental Health Services. The range of covered Mental Health services are described in Sections 700 through 716 of these rules. (7-1-06)T

a. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (7-1-06)T

b. Mental Health Clinic services are described in Sections 7~~1~~0<u>7</u> through 71~~6~~<u>8</u>. ~~(7-1-06)T~~<u>(7-1-06)T</u>

11. Home Health Services. Home health services are described in Sections 720 through 726 of these rules. (7-1-06)T

12. Therapies. Physical therapy services are described in Sections 730 through 736 of these rules. Speech and Occupational Therapy services are referred to in Section 738 of these rules. (7-1-06)T

13. Speech Language and Hearing Services. Audiology services are described in Sections 740 through 746 of these rules. (7-1-06)T

14. Durable Medical Equipment and Supplies. The range of covered durable medical equipment and supplies is described in Sections 750 through 776 of these rules. (7-1-06)T

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (7-1-06)T

b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (7-1-06)T

c. Prosthetic and orthotic services are described in Sections 770 through 776. (7-1-06)T

15. Vision Services. Vision services are described in Sections 780 through 786 of these rules. (7-1-06)T

16. Dental Services. The range of covered dental and ~~*tenderest*~~ *denturist* services is described in Sections 800 through 806 of these rules. ~~*(7-1-06)T*~~(7-1-06)T

17. Essential Providers. The range of covered essential services is described in Sections 820 through 856 of these rules. (7-1-06)T

a. Rural health clinic services are described in Sections 820 through 826. (7-1-06)T

b. Federally Qualified Health Center services are described in Sections 830 through 836. (7-1-06)T

c. Indian Health Services Clinic services are described in Sections 840 through 846. (7-1-06)T

d. School-Based services are described in Sections 850 through 856. (7-1-06)T

18. Transportation. The range of covered transportation services is described in Sections 860 through 876 of these rules. (7-1-06)T

a. Emergency transportation services are described in Sections 860 through 866. (7-1-06)T

b. Non-emergency transportation services are described in Sections 870 through 876. (7-1-06)T

19. EPSDT Services. EPSDT services are described in Sections 880 through 886 of these rules. (7-1-06)T

20. Specific Pregnancy-Related Services. Specific pregnancy-related services are described in Sections 890 through 896 of these rules. (7-1-06)T

COVERED SERVICES
(Sections 400 Through 899)

SUB AREA A: HOSPITAL SERVICES
(Sections 400 Through 449)

400. INPATIENT HOSPITAL SERVICES - DEFINITIONS.

01. Administratively Necessary Day (AND). An Administratively Necessary Day (AND) is intended to allow a hospital time for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for nursing facility level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. (7-1-06)T

02. Allowable Costs. The current year's Medicaid apportionment of a hospital's allowable costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. (7-1-06)T

03. Apportioned Costs. Apportioned costs consist of the share of a hospital's total allowable costs attributed to Medicaid program participants and other patients so that the share borne by the program is based upon actual services received by program participants, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in the PRM and in compliance with Medicaid reimbursement rules. (7-1-06)T

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (7-1-06)T

05. Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups, including but not limited to, those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the current year will be divided by the index of the principal year to assess the percent change between the years. (7-1-06)T

06. Charity Care. Charity care is care provided to individuals who have no source of

payment, third- party or personal resources. (7-1-06)T

07. Children's Hospital. A Medicare-certified hospital as set forth in 42 CFR Section 412.23(d) (7-1-06)T

~~**08. Cost Report**. The complete Medicare cost reporting form CMS 2552, or its successor, as completed in full and accepted by the Intermediary for Medicare cost settlement and audit. (7-1-06)T~~

0~~9~~8. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (7-1-06)T

~~1~~09. Customary *Hospital* Charges. Customary *hospital* charges reflect the regular rates for inpatient or outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. No more than ninety-six and a half percent (96.5%) of covered charges will be reimbursed for the separate operating costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in Subsection 405.03.b. of these rules. ~~(7-1-06)T~~(7-1-06)T

1~~1~~0. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH allotment amount determined by CMS that is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. (7-1-06)T

1~~2~~1. Disproportionate Share Hospital (DSH) Survey. The DSH survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH in accordance with Subsection 405.09.a. of these rules. (7-1-06)T

1~~3~~2. Disproportionate Share Threshold. The disproportionate share threshold is: (7-1-06)T

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (7-1-06)T

b. A Low Income Revenue Rate exceeding twenty-five percent (25%). (7-1-06)T

1~~4~~3. Excluded Units. Excluded units are distinct units in hospitals which are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system. (7-1-06)T

1~~5~~4. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. (7-1-06)T

1~~6~~5. Low Income Revenue Rate. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (7-1-06)T

a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash

subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus (7-1-06)T

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments county assistance programs. (7-1-06)T

1~~7~~6. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. (7-1-06)T

1~~8~~7. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH survey. In this paragraph, the term "inpatient days" includes Medicaid swing-bed days, administratively necessary days, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. In this paragraph, "Medicaid inpatient days" includes paid days not counted in prior DSH threshold computations. (7-1-06)T

1~~9~~8. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. (7-1-06)T

~~20~~19. On-Site. A service location over which the hospital exercises financial and administrative control. "Financial and administrative control" means a location whose relation to budgeting, cost reporting, staffing, policy- making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location must be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g. from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital). (7-1-06)T

2~~1~~0. Operating Costs. For the purposes of hospital reimbursement, operating costs are the allowable costs included in the cost centers established in the finalized Medicare cost report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step- down process. (7-1-06)T

2~~2~~1. Other Allowable Costs. Other allowable costs are those reasonable costs recognized under the Medicaid reasonable cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as operating

costs, but recognized by Medicare principles as allowable costs will be included in the total reasonable costs. Other allowable costs include, but are not necessarily limited to, physician's component which was combined-billed, capital costs, ambulance costs, excess costs, carry-forwards and medical education costs. (7-1-06)T

2~~3~~2. Principal Year. The principal year is the period from which the Medicaid Inpatient Operating Cost Limit is derived. (7-1-06)T

~~**a.** *For services rendered from July 1, 1987 through July 5, 1995, the principal year is the provider's fiscal year ending in calendar year 1984 in which a finalized Medicare cost report or its equivalent is prepared for Medicaid cost settlement.* (7-1-06)T~~

~~**b.** *For inpatient services rendered after July 5, 1995, through June 30, 1998, the principal year is the provider's fiscal year ending in calendar year 1992 in which a finalized Medicare cost report, or its equivalent, is prepared for Medicaid cost settlement.* (7-1-06)T~~

~~**c.** *For inpatient services rendered after June 30, 1998, the principal year is the provider's fiscal year ending in calendar year 1995 in which a finalized Medicare cost report or its equivalent is prepared for Medicaid cost settlement.* (7-1-06)T~~

~~**d**~~**a.** For inpatient services rendered on or after November 1, 2002, the principal year is the provider's fiscal year ending in calendar year 1998 in which a finalized Medicare cost report or its equivalent is prepared for Medicaid cost settlement. (7-1-06)T

b. *For inpatient services rendered on or after January 1, 2007, the principal year is the provider's fiscal year ending in calendar year 2003 and every subsequent fiscal year-end in which a finalized Medicare cost report, or its equivalent, is prepared for Medicaid cost settlement.* (7-1-06)T

2~~4~~3. Public Hospital. For purposes of Subsection 405.03.b. of these rules, a Public Hospital is a hospital operated by a federal, state, county, city, or other local government agency or instrumentality. (7-1-06)T

2~~5~~4. Reasonable Costs. Except as otherwise provided in Section 405.03 of these rules, reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service which do not exceed the Medicaid cost limit. (7-1-06)T

2~~6~~5. Reimbursement Floor Percentage. The percentage of allowable Medicaid costs guaranteed to all hospitals licensed and Medicare certified for State Fiscal Year Ending November 1, 2002, and thereafter - eighty one and a half percent (81.5%). (7-1-06)T

2~~7~~6. TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. (7-1-06)T

2~~8~~7. Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the state Allotment Amount, only inpatient costs of uninsured patients will be

considered. An inpatient with insurance but no covered benefit for the particular medically necessary service, procedure or treatment provided is an uninsured patient. (7-1-06)T

2~~9~~8. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (7-1-06)T

401. (RESERVED).

402. INPATIENT HOSPITAL SERVICES - COVERAGE AND LIMITATIONS.
The policy, rules and regulations to be followed will be those cited in 42 CFR 456.50 through 42 CFR 456.145. (7-1-06)T

01. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services: (7-1-06)T

a. Payment for accommodations is limited to the hospital's all-inclusive rate. *The all-inclusive rate is a flat fee charge incurred on a daily basis that covers both room and board.* ~~*(7-1-06)T*~~(7-1-06)T

b. The Department must not authorize reimbursement above the all-inclusive rate unless the attending physician orders a ~~*special*~~ room *that is not an all-inclusive rate room* for the patient because of medical necessity. ~~*(7-1-06)T*~~(7-1-06)T

02. Limitation of Administratively Necessary Days (ANDs). Each participant is limited to no more than three (3) ANDs per discharge. In the event that a nursing facility level of care is required, an AND may be authorized provided that the hospital documents that no nursing facility bed is available within twenty-five (25) miles of the hospital. (7-1-06)T

403. INPATIENT HOSPITAL SERVICES - PROCEDURAL REQUIREMENTS.
When Administratively Necessary Days are requested, the hospital must provide the Department with complete and timely documentation prior to the participant's anticipated discharge date in order to be considered. Authorization for reimbursement will be denied for all untimely requests and tardy submittal of requested documentation. All requests for AND must be made in writing or by telephone. Hospitals must make the documentation and related information requested by the Department available within ten (10) working days of the date of the request in order for subsequent payment to be granted. The documentation provided by the hospital will include, but is not limited to: (7-1-06)T

01. A Brief Summary. A brief summary of the participant's medical condition; and (7-1-06)T

02. Statements. Statements as to why the participant cannot receive the necessary medical services in a nonhospital setting; and (7-1-06)T

03. Documentation. Documentation that the hospital has diligently made every effort to locate, without success, a facility or organization which is able and willing to deliver the appropriate care. Such evidence must include a list of facilities and organizations, the dates of contact, the names of the persons contacted, and the result of each contact. (7-1-06)T

404. INPATIENT HOSPITAL SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
In addition to the provider enrollment agreement, each claim submitted by a hospital constitutes an agreement by which the hospital agrees to accept and abide by the Department's rules. Only a Medicare certified hospital, licensed by the state in which it operates, may enroll in the Idaho Medicaid program. Hospitals not participating as a Medicaid swing-bed provider, which are licensed for long-term care or as a specialty hospital which provides a nursing home level of care, will be reimbursed as a nursing facility. Hospitals not eligible for enrollment which render emergency care will be paid rates established in these rules. (7-1-06)T

405. INPATIENT HOSPITAL SERVICES - PROVIDER REIMBURSEMENT.
Under the Medicaid provisions of the Social Security Act, in reimbursing hospitals, the Department will pay the lesser of customary *hospital* charges or the reasonable cost of inpatient services in accordance with the procedures detailed under this Section of rule. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. ~~*(7-1-06)T*~~(7-1-06)T

01. Exemption of New Hospitals. A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of reasonable cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, in accordance with 42 CFR Section 413.64. (7-1-06)T

02. Medicaid Inpatient Operating Cost Limits. The following describe the determination of inpatient operating cost limits. (7-1-06)T

a. Medicaid Cost Limits for Dates of Service Prior to a Current Year. The reimbursable reasonable costs for services rendered prior to the beginning of the principal year, but included as prior period claims in a subsequent period's cost report, will be subject to the same operating cost limits as the claims under settlement. (7-1-06)T

b. Application of the Medicaid Cost Limit. In the determination of a hospital's reasonable costs for inpatient services rendered after the effective date of a principal year, a Hospital Inflation Index, computed for each hospital's fiscal year end, will be applied to the operating costs, excluding capital costs and other allowable costs as defined for the principal year and adjusted on a per diem basis for each subsequent year under the Hospital Inflation Index. (7-1-06)T

i. Each inpatient routine service cost center, as reported in the finalized principal year end Medicare Cost Report, will be segregated in the Medicaid cost limit calculation and assigned a share of total Medicaid inpatient ancillary costs. The prorated ancillary costs will be determined by the ratio of each Medicaid routine cost center's reported costs to total Medicaid inpatient routine service costs in the principal year. (7-1-06)T

ii. Each routine cost center's total Medicaid routine service costs plus the assigned

share of Medicaid inpatient ancillary costs of the principal year will be divided by the related Medicaid patient days to identify the total costs per diem in the principal year. (7-1-06)T

(1) The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Subsection 405.02.b.ii. of this rule to identify each inpatient routine service cost center per diem cost limit in the principal year. (7-1-06)T

(2) If a provider did not have any Medicaid inpatient utilization or render any Medicaid inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the principal year, the principal year for only those routine cost centers without utilization in the provider's principal year will be appropriately calculated using the information available in the next subsequent year in which Medicaid utilization occurred. (7-1-06)T

iii. Each routine cost center's cost per diem for the principal year will be multiplied by the Hospital Inflation Index for each subsequent fiscal year. (7-1-06)T

iv. The sum of the per diem cost limits for the Medicaid inpatient routine service cost centers of a hospital during the principal year, as adjusted by the Hospital Inflation Index, will be the Medicaid cost limit for operating costs in the current year. (7-1-06)T

(1) At the date of final settlement, reimbursement of the Medicaid current year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem operating costs as adjusted for each subsequent fiscal year after the principal year through the current year by the Hospital Inflation Cost Index. (7-1-06)T

(2) Providers will be notified of the estimated inflation index periodically or Hospital Inflation Index (CMS Market Basket Index) prior to final settlement only upon written request. (7-1-06)T

03. Adjustments to the Medicaid Cost Limit. A hospital's request for review by the Department concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Section 405 of this chapter of rules, must be granted under the following circumstances: (7-1-06)T

a. Adjustments. Because of Extraordinary Circumstances. Where a provider's costs exceed the Medicaid limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (7-1-06)T

b. Reimbursement to Public Hospitals. A Public Hospital that provides services free or at a nominal charge, which is less than, or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to, or greater than, its costs. (7-1-06)T

c. Adjustment to Cost Limits. A hospital is entitled to a reasonable increase in its

Medicaid Cost limits if the hospital shows that its per diem costs of providing services have increased due to increases in case- mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the principal year. Any hospital making such showing is entitled to an increase commensurate with the increase in per diem costs. (7-1-06)T

i. The Medicaid operating cost limit may be adjusted by multiplying cost limit by the ratio of the current year's Case-Mix Index divided by the principal year's Case-Mix Index. (7-1-06)T

ii. The contested case procedure set for forth in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," is available to larger hospitals seeking such adjustments to their Medicaid Cost Limits. (7-1-06)T

d. Medicaid Operating and Capital and Medical Education Costs. All hospitals will be guaranteed at least eighty percent (80%) of their total allowable Medicaid Operating and Capital and medical education costs upon final settlement excluding DSH payments. (7-1-06)T

i. With the exception of Subsection 405.03.d.ii. of this rule, at the time of final settlement, the allowable Medicaid costs related to each hospital's fiscal year end will be according to the Reimbursement Floor Percentage. (7-1-06)T

ii. In the event that CMS informs the Department that total hospital payments under the Inpatient Operating Cost Limits exceed the inpatient Upper Payment Limit, the Department may reduce the guaranteed percentage defined as the Reimbursement Floor Percentage to hospitals. (7-1-06)T

e. Adjustment to the Proration of Ancillary Costs in the principal year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total Medicaid cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each participant for each type of patient day during each participant's stay during the principal year. The provider will be granted this adjustment only once upon appeal for the first cost reporting year that the limits are in effect. (7-1-06)T

04. Payment Procedures. The following procedures are applicable to in-patient hospitals: (7-1-06)T

a. The participant's admission and length of stay is subject to preadmission, concurrent and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. 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 QIO review as required by Section 405 of this chapter of rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a 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 405.05 of this rule. (7-1-06)T

i. All admissions are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the participant's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. (7-1-06)T

ii. Reimbursement for services originally identified as not medically necessary by the QIO will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-06)T

iii. Absent the Medicaid participant's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be obtained from the participant. (7-1-06)T

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary *hospital* charges or the reasonable cost of semi-private rates for in-patient hospital care ~~*in accordance with the rules*~~ *as* set forth in ~~*Idaho*~~ in ~~*these*~~ *this* rule~~s~~*, unless an exception applies as stated in Section 402 of these rules*. The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. ~~*(7-1-06)T*~~(7-1-06)T

05. Hospital Penalty Schedule. (7-1-06)T

a. A request for a preadmission and/or continued stay 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. (7-1-06)T

b. A request for a preadmission and/or continued stay 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. (7-1-06)T

c. A request for a preadmission and/or continued stay 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. (7-1-06)T

d. A request for a preadmission and/or continued stay 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. (7-1-06)T

e. A request for a preadmission and/or continued stay 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. (7-1-06)T

06. AND Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/MR rates are excluded from this calculation. (7-1-06)T

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (7-1-06)T

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (7-1-06)T

c. The Department will pay the lesser of the established AND rate or a facility's customary *hospital* charge to private pay patients for an AND. ~~*(7-1-06)T*~~(7-1-06)T

07. Reimbursement for Services. Routine services as addressed in Subsection 405.08 of this rule include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (7-1-06)T

08. Hospital Swing-Bed Reimbursement. The Department will pay for nursing facility care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to participants in licensed hospital ("swing") beds who require nursing facility level of care. (7-1-06)T

a. Facility Requirements. The Department will approve hospitals for nursing facility care provided to eligible participants under the following conditions: (7-1-06)T

i. The Department's Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.66 "Special Requirements" for hospital providers of long-term care services ("swingbeds"); and (7-1-06)T

ii. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and (7-1-06)T

iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and (7-1-06)T

iv. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (7-1-06)T

v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.66(a)(1) for swing-bed purposes; and (7-1-06)T

vi. Nursing facility services in swing-beds must be rendered in beds used interchangeably to furnish hospital or nursing facility-type services. (7-1-06)T

b. Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: (7-1-06)T

i. The participant is determined to be entitled to such services in accordance with

IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled"; and (7-1-06)T

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 222.02. (7-1-06)T

c. Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (7-1-06)T

i. Payment rates for routine nursing facility services will be at the weighted average Medicaid rate per patient day paid to hospital-based nursing facility/ICF facilities for routine services furnished during the previous calendar year. ICF/MR facilities' rates are excluded from the calculations. (7-1-06)T

ii. The rate will be calculated by the Department by March 15 of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (7-1-06)T

iii. The weighted average rate for nursing facility swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (7-1-06)T

iv. Routine services include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 225.01. (7-1-06)T

v. The Department will pay the lesser of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. (7-1-06)T

vi. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (7-1-06)T

vii. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety five (1,095) days which may be prorated over a shorter fiscal period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. (7-1-06)T

d. Computation of "Swing-Bed" Patient Contribution. The computation of the patient's contribution of swing-bed payment will be in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 224. (7-1-06)T

09. Adjustment for Disproportionate Share Hospitals (DSH). All hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment (7-1-06)T

a. DSH Survey Requirements. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. The DSH survey must be returned to the Department on or before May 31 of the same calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. No later than July 15 of each calendar year, the Department must notify each hospital of their calculated DSH payment and notify each hospital of its preliminary calculated distribution amount. A hospital may file an amended survey to complete, correct, or revise the original DSH survey by submitting the amended survey and supporting documentation to the Department no later than thirty (30) days after the notice of the preliminary DSH calculation is mailed to the hospital. The state's annual DSH allotment payment will be made by September 30 of the same calendar year based on the final DSH surveys and Department data. (7-1-06)T

b. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals which: (7-1-06)T

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. (7-1-06)T

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services, and have provided such services to individuals entitled to such services under the Idaho Medical Assistance Program for the reporting period. (7-1-06)T

(1) Subsection 405.09.b.ii. of this rule does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (7-1-06)T

(2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (7-1-06)T

iii. The MUR will not be less than one percent (1%). (7-1-06)T

iv. If a hospital exceeds both disproportionate share thresholds, as described in Subsection 400.13 of these rules, and the criteria of Subsections 405.09.b.ii. and 405.09.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.09.b.vi. through 405.09.b.x. of this rule. (7-1-06)T

v. In order to qualify for a DSH payment, a hospital located outside the state of Idaho must: (7-1-06)T

(1) Qualify under the Mandatory DSH requirements set forth in S*ubs*ection 405.*09* of this chapter of rules; ~~*(7-1-06)T*~~(7-1-06)T

(2) Qualify for DSH payments from the state in which the hospital is located; and (7-1-06)T

(3) Have fifty thousand dollars ($50,000) or more in covered charges for services provided to Idaho participants during the year covered by the applicable DSH survey. (7-1-06)T

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-06)T

vii. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-06)T

viii. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-06)T

ix. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-06)T

x. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-06)T

c. Out-of-State Hospitals Eligible for Mandatory DSH Payments. Out-of-state hospitals eligible for Mandatory DSH payments will receive DSH payments equal to one half (1/2) of the percentages provided for Idaho hospitals in Subsections 405.09.b.iv. through 405.09.b.x. of this rule. (7-1-06)T

d. Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 405.09.b. of this rule, will be designated a Deemed Disproportionate Share Hospital. Out of state hospitals will not be designated as Deemed DSH. The disproportionate share payment to a Deemed DSH hospital will be the greater of: (7-1-06)T

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (7-1-06)T

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (7-1-06)T

e. Insufficient DSH Allotment Amounts. When the DSH allotment amount is

insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (7-1-06)T

f. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (7-1-06)T

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third party payment. (7-1-06)T

ii. Claims of uninsured costs which increase the maximum amount which a hospital may receive as a DSH payment must be documented. (7-1-06)T

g. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (7-1-06)T

10. Out-of-State Hospitals. (7-1-06)T

a. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the state of Idaho will have a cost settlement computed with the state of Idaho if the following conditions are met: (7-1-06)T

i. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (7-1-06)T

ii. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (7-1-06)T

b. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (7-1-06)T

11. Institutions for Mental Disease (IMD). Except for individuals under twenty-two (22) years of age which are contracted with the Department under the authority of the Division of Family and Community Services and certified by the Health Care Financing Administration, no services related to inpatient care will be covered when admitted to a freestanding psychiatric hospital. (7-1-06)T

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

13. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (7-1-06)T

14. Availability of Records of Hospital Providers. A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (7-1-06)T

15. Interim Cost Settlements. The Department may initiate or a hospital may request an interim cost settlement based on the Medicare cost report as submitted to the Medicare Intermediary. (7-1-06)T

a. Cost Report Data. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (7-1-06)T

b. Hard Copy of Cost Report. Hospitals which request to undergo interim cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Department upon filing with the Intermediary. (7-1-06)T

c. Limit or Recovery of Payment. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (7-1-06)T

16. Notice of Program Reimbursement. Following receipt of the finalized Medicare Cost Report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If

the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (7-1-06)T

a. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the Cost Report from the Medicare Intermediary. (7-1-06)T

b. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the Cost Report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (7-1-06)T

~~***17. Interest Charges on Overpayments and Underpayments to Hospitals**. The Medicaid program will charge interest on overpayments, and pay interest on underpayments, to hospitals as follows: (7-1-06)T*~~

~~***a.** Interest After Sixty Days of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement as defined in Section 405.16 of this rule, and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. (7-1-06)T*~~

~~***b.** Waiver of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges. (7-1-06)T*~~

~~***c.** Rate of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly. (7-1-06)T*~~

~~***d.** Retroactive Adjustment. The balance and interest will be retroactively adjusted to equal the amounts that would have been due based on any changes which occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties will only applied to unpaid amounts and will be subordinated to final interest determinations made in the judicial review process. (7-1-06)T*~~

~~***18. Recovery Methods**. Recovery will be effected by one (1) of the following methods: (7-1-06)T*~~

~~***a.** Lump Sum Voluntary Repayment. Pursuant to the provider's receipt of the notice of program reimbursement, the provider refunds the entire overpayment to the Department. (7-1-06)T*~~

~~*b. Periodic Voluntary Repayment. The provider must request in writing that recovery of the overpayment be made over a period of twelve (12) months or less. The provider must adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested.* (7-1-06)T~~

~~*c. Department Initiated Recovery. The Department will recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receipt.* (7-1-06)T~~

~~*d. Recovery From Medicare Payments. The Department may request that Medicare payments be withheld in accordance with 42 CFR Section 405.376.* (7-1-06)T~~

1~~9~~7. Nonappealable Items. The formula for the determination of the Hospital Inflation Index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits must not be accepted as appealable items. (7-1-06)T

~~20~~18. Interim Reimbursement Rates. The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (7-1-06)T

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (7-1-06)T

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (7-1-06)T

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. (7-1-06)T

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (7-1-06)T

~~21~~9. Audits. All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (7-1-06)T

406. INPATIENT HOSPITAL SERVICES - QUALITY ASSURANCE.
The designated QIO must prepare, distribute and maintain a provider manual, that must be

periodically updated. The manual will include the following: (7-1-06)T

01. QIO Information. The QIO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. (7-1-06)T

02. Department Provisions. Department-selected diagnoses and elective procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay . (7-1-06)T

03. Approval Timeframe. A provision that the 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. (7-1-06)T

04. Method of Notice. The method of notice to hospitals of QIO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. (7-1-06)T

05. Procedural Information. The procedures which providers or participants will use to obtain reconsideration of a denial by the QIO prior to appeal to the Department. Such requests for reconsideration by the QIO must be made in writing to the QIO within one hundred eighty (180) days of the issuance of the "Notice of Non-Certification of Hospital Days". (7-1-06)T

410. OUTPATIENT HOSPITAL SERVICES - DEFINITIONS.
Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative or palliative items, and services furnished by or under the direction of a physician or dentist, unless excluded by any other provisions of this chapter. (7-1-06)T

411. (RESERVED).

412. OUTPATIENT HOSPITAL SERVICES - COVERAGE AND LIMITATIONS.

01. Services Provided On-Site. Outpatient hospital services must be provided on-site. (7-1-06)T

02. Exceptions and Limitations. (7-1-06)T

a. Payment for emergency room service is limited to six (6) visits per calendar year. (7-1-06)T

b. Emergency room services which are followed immediately by admission to inpatient status will be excluded from the six (6) visit limit. (7-1-06)T

413. OUTPATIENT HOSPITAL SERVICES - PROCEDURAL REQUIREMENTS.
Failure to obtain a timely review from the Department 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 participants 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 405.05 of these rules, when a review is conducted due to an untimely

request. (7-1-06)T

414. (RESERVED).

415. OUTPATIENT HOSPITAL SERVICES - PROVIDER REIMBURSEMENT.

01. Outpatient Hospital. The Department will not pay more than the combined payments the provider is allowed to receive from the participants and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. Outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year end cost settlement. (7-1-06)T

a. Maximum payment for hospital outpatient diagnostic laboratory services will be limited to the Department's established fee schedule. (7-1-06)T

b. Maximum payment for hospital outpatient partial care services will be limited to the Department's established fee schedule. (7-1-06)T

c. Hospital-based ambulance services will be reimbursed at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service as established by the Department in its pricing file. (7-1-06)T

d. Hospital Outpatient Surgery. Those items furnished by a hospital to an outpatient in connection with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of: (7-1-06)T

i. The hospital's reasonable costs as reduced by federal mandates for certain operating costs, capital costs, customary *hospital* charges; or ~~*(7-1-06)T*~~(7-1-06)T

ii. The blended payment amount which is based on hospital specific cost and charge data and Medicaid rates paid to free-standing Ambulatory Surgical Centers (ASC); or (7-1-06)T

iii. The blended rate of costs and the Department's fee schedule for ambulatory surgical centers at the time of cost settlement; or (7-1-06)T

iv. The blended rate for outpatient surgical procedures is equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount. (7-1-06)T

e. Hospital Outpatient Radiology Services include diagnostic and therapeutic radiology, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services. The aggregate payment for hospital outpatient radiology services furnished will be equal to the lesser of: (7-1-06)T

i. The hospital's reasonable costs; or (7-1-06)T

ii. The hospital's customary charges; or (7-1-06)T

iii. The blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount. (7-1-06)T

02. Reduction to Outpatient Hospital Costs. With the exception of Medicare designated sole community hospitals and rural primary care hospitals, all other hospital outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of operating costs and ten percent (10%) of each hospital's capital costs component. (7-1-06)T

416. -- 421. (RESERVED).

422. RECONSTRUCTIVE SURGERY - COVERAGE AND LIMITATIONS.
Reconstruction or restorative procedures that may be rendered with prior approval by the Department include procedures that restore function of the affected or related body part(s). Approvable procedures include breast reconstruction after mastectomy, or the repair of other injuries resulting from physical trauma. (7-1-06)T

423. -- 430. (RESERVED).

431. SURGICAL PROCEDURES FOR WEIGHT LOSS - PARTICIPANT ELIGIBILITY.
Surgery for the correction of obesity is covered when all of the following conditions are met: (4-7-05)T

01. Participant Medical Condition. The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than forty (40), or a BMI equal to or greater than thirty-five (35) with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities. The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition who is not associated by clinic or other affiliation with the surgeons who will perform the surgery. (4-7-05)T

02. Other Medical Condition Exists. The obesity is caused by the serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory or other systemic disease. (4-7-05)T

03. Psychiatric Evaluation. The participant must have a psychiatric evaluation to determine the stability of personality at least ninety (90) days prior to the date a request for prior authorization is submitted to Medicaid. (4-7-05)T

432. SURGICAL PROCEDURES FOR WEIGHT LOSS - COVERAGE AND LIMITATIONS.

01. Non-Surgical Treatment for Obesity. Services in connection with non-surgical

treatment of obesity are covered only when such services are an integral and necessary part of treatment for another medical condition that is covered by Medicaid. (4-7-05)T

02. Abdominoplasty or Panniculectomy. Abdominoplasty or panniculectomy is covered when medically necessary, as defined in Section 011 of these rules, and when the surgery is prior authorized by the Department. The request for prior authorization must include the following documentation: (4-7-05)T

a. Photographs of the front, side and underside of the participant's abdomen; (4-7-05)T

b. Treatment of any ulceration and skin infections involving the panniculus; (4-7-05)T

c. Failure of conservative treatment, including weight loss; (4-7-05)T

d. That the panniculus severely inhibits the participant's walking; (4-7-05)T

e. That the participant is unable to wear a garment to hold the panniculus up; and (4-7-05)T

f. Other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body. (4-7-05)T

433. SURGICAL PROCEDURES FOR WEIGHT LOSS - PROCEDURAL REQUIREMENTS.

01. Medically Necessary. The Department must determine the surgery to be medically necessary, as defined in Section 011 of these rules. (4-7-05)T

02. Prior Authorization. The surgery must be prior authorized by the Department. The Department will consider the guidelines of private and public payors, evidence-based national standards of medical practice, and the medical necessity of each participant's case when determining whether surgical correction of obesity will be prior authorized. (4-7-05)T

434. SURGICAL PROCEDURES FOR WEIGHT LOSS - PROVIDER QUALIFICATIONS AND DUTIES.
Physicians and hospitals must meet national medical standards for weight loss surgery. (4-7-05)T

435. -- 442. (RESERVED).

443. INVESTIGATIONAL PROCEDURES OR TREATMENTS - PROCEDURAL REQUIREMENTS.
The Department may consider Medicaid coverage for investigational procedures or treatments on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. For these cases, a focused case review is completed by a professional medical review organization to determine if an investigational procedure would be beneficial to the participant. The Department will perform a cost-benefit analysis on the procedure or treatment in question.

The Department will determine coverage based on this review and analysis. (4-7-05)T

01. Focused Case Review. A focused case review consists of assessment of the following: (4-7-05)T

a. Health benefit to the participant of the proposed procedure or treatment; (4-7-05)T

b. Risk to the participant associated with the proposed procedure or treatment; (4-7-05)T

c. Result of standard treatment for the participant's condition, including alternative treatments other than the requested procedure or treatment; (4-7-05)T

d. Specific inclusion or exclusion by Medicare national coverage guidelines of the proposed procedure or treatment; (4-7-05)T

e. Phase of the clinical trial of the proposed procedure or treatment; (4-7-05)T

f. Guidance regarding the proposed procedure or treatment by national organizations; (4-7-05)T

g. Clinical data and peer-reviewed literature pertaining to the proposed procedure or treatment; and (4-7-05)T

h. Ethics Committee review, if appropriate. (4-7-05)T

02. Additional Clinical Information. For cases in which the Department determines that there is insufficient information from the focused case review to render a coverage decision, the Department may, at its discretion, seek an independent professional opinion. (4-7-05)T

03. Cost-Benefit Analysis. The Department will perform a cost-benefit analysis that will include at least the following: (4-7-05)T

a. Estimated costs of the procedure or treatment in question. (4-7-05)T

b. Estimated long-term medical costs if this procedure or treatment is allowed. (4-7-05)T

c. Estimated long-term medical costs if this procedure is not allowed. (4-7-05)T

d. Potential long-term impacts approval of this procedure or treatment may have on the Medical Assistance Program. (4-7-05)T

04. Coverage Determination. The Department will make a decision about coverage of the investigational procedure or treatment after consideration of the focused case review, cost-benefit analysis, and any additional information received during the review process. (4-7-05)T

444. -- 449. (RESERVED).

SUB AREA B: AMBULATORY SURGICAL CENTERS
(Sections 450 Through 499)

450. -- 451. (RESERVED).

452. AMBULATORY SURGICAL CENTER SERVICES - COVERAGE AND LIMITATIONS.
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 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). (7-1-06)T

453. RESERVED.

454. AMBULATORY SURGICAL CENTER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Approval. The ASC must be surveyed by the Department's 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. (7-1-06)T

02. Cancellation. Grounds for cancellation of the provider agreement include: (7-1-06)T

a. The loss of Medicare program approval; (7-1-06)T

b. Identification of any condition that threatens the health or safety of patients by the Department's Bureau of Facility Standards. (7-1-06)T

455. AMBULATORY SURGICAL CENTER SERVICES - PROVIDER REIMBURSEMENT.

01. 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: (7-1-06)T

a. ASC 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, but which is not covered by Medicare will have a reimbursement rate established by the Department. (7-1-06)T

b. ASC services include the following: (7-1-06)T

i. Nursing, technician, and related services; (7-1-06)T

ii. Use of ASC facilities; (7-1-06)T

iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; (7-1-06)T

iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; (7-1-06)T

v. Administration, record-keeping and housekeeping items and services; and (7-1-06)T

vi. Materials for anesthesia. (7-1-06)T

c. ASC services do not include the following services: (7-1-06)T

i. Physician services; (7-1-06)T

ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); (7-1-06)T

iii. Prosthetic and orthotic devices; (7-1-06)T

iv. Ambulance services; (7-1-06)T

v. Durable medical equipment for use in the patient's home; and (7-1-06)T

vi. Any other service not specified in Subsection 455.01.b. of this rule. (7-1-06)T

02. Payment for Ambulatory Surgical Center Services. Payment is made at a rate established in accordance with Section 230 of these rules. (7-1-06)T

456. -- 499. (RESERVED).

SUB AREA C: PHYSICIAN SERVICES AND ABORTION PROCEDURES
(Sections 500 Through 519)

500. PHYSICIAN SERVICES - DEFINITIONS.
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 390 and Subsection 502.01 of these rules. (7-1-06)T

501. (RESERVED).

502. PHYSICIAN SERVICES - COVERAGE AND LIMITATIONS.

01. Outpatient Psychiatric Mental Health Services. Outpatient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible participant 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. (7-1-06)T

02. Sterilization Procedures. Particular restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. (7-1-06)T

03. Abortions. Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. (7-1-06)T

04. Tonometry. 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 participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. (7-1-06)T

05. Physical Therapy Services. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis. (7-1-06)T

06. Injectable Vitamins. 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. (7-1-06)T

07. Corneal Transplants and Kidney Transplants. Corneal transplants and kidney transplants are covered by the Medical Assistance Program. (7-1-06)T

503. (RESERVED).

504. PHYSICIAN SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

01. 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. (7-1-06)T

02. Locum Tenens Claims and Reciprocal Billing. (7-1-06)T

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: (7-1-06)T

i. The regular physician is unavailable to provide the visit services. (7-1-06)T

ii. The Medicaid patient has arranged for or seeks to receive services from the regular physician. (7-1-06)T

iii. The regular physician pays the Locum Tenens for his services on a per diem or similar fee-for-time basis. (7-1-06)T

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. (7-1-06)T

v. The regular physician identifies the services as substitute physician services meeting the requirements of Section 504 of this chapter of rules 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). (7-1-06)T

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. (7-1-06)T

vii. The claim identifies, in a manner specified by the Department, the physician who furnished the services. (7-1-06)T

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 must not be reported separately on the claim as substitution services, but must be deemed as included in the global fee payment. (7-1-06)T

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. (7-1-06)T

505. PHYSICIAN SERVICES - PROVIDER REIMBURSEMENT.

01. Physician Penalties for Late QIO Review. Medicaid will assess the physician a penalty for failure to request a preadmission review from the Department, 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 405.02.a. of these rules*~~. 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 505.02 of this rule. The penalty will be assessed after payment for physician services has occurred. ~~*(7-1-06)T*~~(7-1-06)T

02. Physician Penalty Schedule. (7-1-06)T

a. A request for preadmission QIO review that is one (1) day late will result in a

penalty of fifty dollars ($50). (7-1-06)T

b. A request for preadmission QIO review that is two (2) days late will result in a penalty of one hundred dollars ($100). (7-1-06)T

c. A request for preadmission QIO review that is three (3) days late will result in a penalty of one hundred and fifty dollars ($150). (7-1-06)T

d. A request for preadmission QIO review that is four (4) days late will result in a penalty of two hundred dollars ($200). (7-1-06)T

e. A request for preadmission QIO review that is five (5) days late or later will result in a penalty of two hundred and fifty dollars ($250). (7-1-06)T

03. 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. (7-1-06)T

506. -- 510. (RESERVED).

511. ABORTION PROCEDURES - PARTICIPANT ELIGIBILITY.
The Department will fund abortions under the Medical Assistance Program 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. (7-1-06)T

512. -- 513. (RESERVED).

514. ABORTION PROCEDURES - PROVIDER QUALIFICATIONS AND DUTIES.

01. Required Documentation in the Case of Rape or Incest. In the case of rape or incest, the following documentation must be provided to the Department: (7-1-06)T

a. A copy of the court determination of rape or incest must be provided; or (7-1-06)T

b. Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency. (7-1-06)T

c. Where the rape or incest was not reported to a law enforcement agency, a licensed physician 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 (7-1-06)T

d. Documentation that the woman was under the age of eighteen (18) at the time of sexual intercourse. (7-1-06)T

02. Required Documentation in the Case Where the Abortion is Necessary to Save the Life of the Woman. In the case where the abortion is necessary to save the life of the

woman, a licensed physician 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. (7-1-06)T

515. -- 519. (RESERVED).

SUB AREA D: OTHER PRACTITIONER SERVICES
(Sections 520 Through 559)

520. -- 521. (RESERVED).

522. MIDLEVEL PRACTITIONER SERVICES - COVERAGE AND LIMITATIONS. The Medicaid Program will pay for services provided by certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), and physician assistants (PA), as defined in Sections 010, 011, 012 of these rules and in accordance with the provisions found under Sections 523 through 525 of these rules. (7-1-06)T

523. (RESERVED).

524. MIDLEVEL PRACTITIONER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

01. Identification of Services. The required services must be covered under the legal scope of practice as identified by the appropriate State rules of the CRNA, NP, NM, or PA. (7-1-06)T

02. Deliverance of Services. The services must be delivered under physician supervision, if required by Idaho Statute. (7-1-06)T

525. MIDLEVEL PRACTITIONER SERVICES - PROVIDER REIMBURSEMENT.

01. Billing of Services. Billing for the services must be as provided by the CRNA, NP, NM, or PA, and not represented as a physician service. (7-1-06)T

02. Payments Made Directly to CRNA. Payments under the fee schedule must be made directly to the CRNA under the individual provider number assigned to the CRNA. Rural hospitals that qualify for a Medicare exception and employ or contract CRNAs may be reimbursed on a reasonable cost basis. (7-1-06)T

03. Reimbursement Limits. The Department will reimburse for each service to be delivered by the NP, NM, or PA as either the billed charge or reimbursement limit established by the Department, whichever is less. (7-1-06)T

526. -- 529. (RESERVED).

530. CHIROPRACTIC SERVICES - DEFINITIONS.

Subluxation is partial or incomplete dislocation of the spine. (7-1-06)T

531. (RESERVED).

532. CHIROPRACTIC SERVICES - COVERAGE AND LIMITATIONS.
The Department will pay for a total of twenty-four (24) manipulation visits during any calendar year for remedial care by a chiropractor but only for treatment involving manipulation of the spine to correct a subluxation condition. (7-1-06)T

533. -- 539. (RESERVED).

540. PODIATRIST SERVICES - DEFINITIONS.
The Department will reimburse podiatrists for treatment of acute foot conditions. Acute foot conditions, for the purpose of this provision, means any condition that hinders normal function, threatens the individual, or complicates any disease. Preventive foot care may be provided if vascular restrictions or other systemic disease is threatened. (7-1-06)T

541. -- 553. (RESERVED).

554. OPTOMETRIST SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
Optometrist services are provided to the extent specified in the individual provider agreements entered into under the provisions of Section 205 of these rules. (7-1-06)T

01. Payment Availability. Payment for services included in Subsection 502.04 and Sections 780 through 786 of these rules is available to all licensed optometrists. (7-1-06)T

02. Provider Agreement Qualifications. Optometrists who have been issued and who maintain certification under the provisions of Sections 54-1501 and 54-1509, Idaho Code, qualify for provider agreements allowing payment for the diagnosis and treatment of injury or disease of the eye to the extent allowed under Section 54-1501, Idaho Code, and to the extent payment is available to physicians as defined in these rules. (7-1-06)T

555. -- 559. (RESERVED).

SUB AREA E: PRIMARY CARE CASE MANAGEMENT
(Sections 560 Through 569)

560. HEALTHY CONNECTIONS - DEFINITIONS.
For purposes of this Sub Area, unless the context clearly requires otherwise, the following words and terms have the following meanings: (7-1-06)T

01. Clinic. Two (2) or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs), Certified Rural Health Clinics, and Indian Health Clinics. (7-1-06)T

02. Covered Services. Those medical services and supplies for which reimbursement is available under the State Plan. (7-1-06)T

03. Grievance. The formal process by which problems and complaints related to Healthy Connections are addressed and resolved. Grievance decisions may be appealed as provided herein. (7-1-06)T

04. Healthy Connections. The provision of health care services through a single point of entry for the purposes of managing participant care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as "managed care". (7-1-06)T

05. Plan. The area specific provisions, requirements and procedures related to Healthy Connections. (7-1-06)T

06. Primary Care Case Management. The process in which a physician is responsible for direct care of a participant, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the participant. (7-1-06)T

07. Primary Care Case Manager. A primary care physician who contracts with Medicaid to coordinate the care of certain participants. (7-1-06)T

08. Qualified Medical Professional. ~~*means a*~~ A duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered.
~~*(7-1-06)T*~~(7-1-06)T

09. Referral. The process by which participants gain access to those covered services subject to primary care case management, but not provided by the primary care provider. It is the authorization for such services. (7-1-06)T

561. HEALTHY CONNECTIONS - PARTICIPANT ELIGIBILITY.

01. Voluntary County. In a voluntary county, the participant will be given an opportunity to choose a primary care provider. If the participant is unable to choose a provider but wishes to participate, a provider will be assigned by the Department. If a voluntary **county** subsequently becomes a mandatory **county**, provider selection and assignment will remain unchanged where possible. (7-1-06)T

02. Mandatory County. In a mandatory county, a provider will be assigned if the participant fails to choose a participating provider after given the opportunity to do so. Members of the same family do not have to choose the same provider. All participants in the county are required to participate unless individually granted an exception. Exceptions from participation in a mandatory county are available for participants who: (7-1-06)T

a. Have to travel more than thirty (30) miles, or thirty (30) minutes to obtain primary

care services; (7-1-06)T

b. Have an eligibility period that is less than three (3) months; (7-1-06)T

c. Have an eligibility period that is only retroactive; (7-1-06)T

d. Are eligible only as Qualified Medicare Beneficiary; (7-1-06)T

e. Have an existing relationship with a primary care physician or clinic who is not participating with the Healthy Connections; or (7-1-06)T

f. Has incompatible third party liability. (7-1-06)T

562. HEALTHY CONNECTIONS - COVERAGE AND LIMITATIONS.

01. Exempted Services. All services are subject to primary care case management unless specifically exempted. The following services are exempt: (7-1-06)T

a. Family planning services; (7-1-06)T

b. Emergency care (as defined by the Department for the purpose of payment and performed in an emergency department); (7-1-06)T

c. Dental care (performed in the office); (7-1-06)T

d. Podiatry (performed in the office); (7-1-06)T

e. Audiology (hearing tests or screening, does not include ear/nose/throat services); (7-1-06)T

f. Optical/Ophthalmology/Optometrist services (performed in the office); (7-1-06)T

g. Chiropractic (performed in the office); (7-1-06)T

h. Pharmacy (prescription drugs only); (7-1-06)T

i. Nursing home; (7-1-06)T

j. ICF/MR services; (7-1-06)T

k. Childhood immunizations (not requiring an office visit); (7-1-06)T

l. Flu shots and/or pneumococcal vaccine (not requiring an office visit); (7-1-06)T

m. Diagnosis and/or treatment for sexually transmitted diseases; (7-1-06)T

n. One screening mammography per calendar year for women age forty (40) or older; (7-1-06)T

o. Indian Health Clinic/638 Clinic services provided to individuals eligible for Indian Health Services; and (7-1-06)T

p. In-home services, known as Personal Care Services and Personal Care Services Case Management (7-1-06)T

02. Change in Services That Require a Referral. The Department may change the services that require a referral after appropriate notification of Medicaid eligible individuals and providers. (7-1-06)T

563. HEALTHY CONNECTIONS - PROCEDURAL REQUIREMENTS.

01. Primary Care Case Management. Under the Healthy Connections model of managed care, each participant obtains medical services through a single primary care provider. This provider either provides the needed service, or makes a referral for needed services. This management function neither reduces nor expands the scope of covered services. (7-1-06)T

a. Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the participant's care, providing primary care services, and making referrals for services when medically necessary. All services not specifically exempted in Section 562 of these rules require a referral. Services that require referral, but are provided without a referral will not be paid. All referrals must be documented in participant's patient record. (7-1-06)T

b. Changing Providers. If a participant is dissatisfied with his provider, he may change providers effective the first day of any month by contacting ~~*their*~~ *his* designated Healthy Connections Representative to do so no later than fifteen (15) days in advance. This advance notice requirement may be waived by the Department. ~~*(7-1-06)T*~~(7-1-06)T

c. Changing Service Areas. Participants who move from the area where they are enrolled must disenroll in the same manner as provided in the preceding paragraph for changing providers, and may obtain a referral from their primary care provider pending the transfer. Such referrals are valid not to exceed thirty (30) days. (7-1-06)T

02. Problem Resolution. (7-1-06)T

a. Intent. To help assure the success of Healthy Connections, the Department intends to provide a mechanism for timely and personal attention to problems and complaints related to the program . (7-1-06)T

b. Local Program Representative. To facilitate problem resolution, each area will have a designated representative who will receive and attempt to resolve all complaints and problems related to the plan and function as a liaison between participants and providers. It is anticipated that most problems and complaints will be resolved informally at this level. (7-1-06)T

c. Registering a Complaint. Both participants and providers may register a complaint or notify the Department of a problem related to Healthy Connections either by writing or telephoning the local program representative. The health representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. (7-1-06)T

d. Grievance. If a participant or provider is not satisfied with the resolution of a problem or complaint addressed by the program representative, he may file a formal grievance in writing to the representative. The manager of the managed care program may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt.(7-1-06)T

e. Appeal. Decisions in response to grievances may be appealed. Appeals by participants are considered as fair hearings and appeals by providers as contested cases under the Rules Governing Contested Case Proceedings and Declaratory Rulings, IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and must be filed in accordance with the provisions of that chapter. (7-1-06)T

564. HEALTHY CONNECTIONS - PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Participation Qualifications. Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered. (7-1-06)T

02. Provider Participation Conditions and Restrictions. (7-1-06)T

a. Quality of Services. Provider must maintain and provide services in accordance with community standards of care. Provider must exercise his best efforts to effectively control utilization of services. Providers must provide twenty-four (24) hour coverage by telephone to assure participant access to services. (7-1-06)T

b. Provider Agreements. Providers participating in primary care case management must sign an agreement. Clinics may sign an agreement on behalf of their qualified medical professionals. (7-1-06)T

c. Patient Limits. Providers may limit the number of participants they wish to manage. Subject to this limit, the provider must accept all participants who either elect or are assigned to provider, unless disenrolled in accordance with Subsection 564.02.d. of this rule. Providers may change their limit effective the first day of any month by written request thirty (30) days prior to the effective date of change. Requirement maybe waived by the Department. (7-1-06)T

d. Disenrollment. Instances may arise where the provider-patient relationship breaks down due to failure of the participant to follow the plan of care or for other reasons. Accordingly, a provider may choose to withdraw as participant's primary care provider effective the first day of any month by written notice to the participant and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department.

(7-1-06)T

e. Record Retention. Providers must retain patient and financial records and provide the Department access to those records for a minimum of six (6) years from the date of service. Upon the reassignment of a participant to another provider, the provider must transfer (if a request is made) a copy of the patient's medical record to the new provider. Provider must also disclose information required by Subsection 205.01 of these rules, when applicable. (7-1-06)T

f. Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 205.03 of these rules. An agreement may be amended for the same reasons. (7-1-06)T

565. HEALTHY CONNECTIONS - PROVIDER REIMBURSEMENT.
Providers will be paid a case management fee for primary care case management services in an amount determined by the Department. The fee will be based on the number of participants enrolled under the provider on the first day of each month. For providers reimbursed based on costs, such as Federally Qualified Health Centers and Rural Health Clinics, the case management fee is considered one hundred percent (100%) of the reasonable costs of an ambulatory service. (7-1-06)T

566. -- 569. (RESERVED).

SUB AREA F: PREVENTION SERVICES
(Sections 570 Through 649)

570. HEALTH QUESTIONNAIRE.
The Health Questionnaire assesses the general health status and health behaviors of a participant. The information collected is used to provide customized health education to the participant. The Health Questionnaire is administered at initial program entry and at periodic intervals thereafter. Participant responses to the issues addressed in the Health Questionnaire may identify a participant's ~~*need for*~~ *interest in* the ~~*Prevention and*~~ *Preventive* Health Assistance benefits described in Section 620 of these rules. ~~*(7-1-06)T*~~*(7-1-06)T*

571. -- 579. (RESERVED).

580. CHILD WELLNESS SERVICES - DEFINITIONS.

01. Interperiodic Medical Screens. Interperiodic medical screens are screens that are done at intervals other than those identified in the American Academy of Pediatrics periodicity schedule. (7-1-06)T

02. Periodic Medical Screens. Interperiodic medical screens are screens done at intervals identified in the American Academy of Pediatrics periodicity schedule. (7-1-06)T

581. CHILD WELLNESS SERVICES - PARTICIPANT ELIGIBILITY.
Child Wellness Services are available to all participants up to, and including, the month of their

twenty-first (21st) birthday. (7-1-06)T

582. CHILD WELLNESS SERVICES - COVERAGE AND LIMITATIONS.

01. Periodic Medical Screens. Periodic medical screens are to be completed according to the American Academy of Pediatrics periodicity schedule including blood lead tests at age twelve (12) months and twenty-four (24) months. The medical screen must include a blood lead test when the participant is age two (2) through age twenty-one (21) and has not been previously tested. (7-1-06)T

02. Interperiodic Screens. Interperiodic screens will be performed when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screens may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary (7-1-06)T

03. Developmental Screens. Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem, then a developmental assessment will be ordered by the physician and be conducted by qualified professionals. (7-1-06)T

583. CHILD WELLNESS SERVICES - PROCEDURAL REQUIREMENTS.
EPSDT RN screeners will routinely refer all participants to primary care providers. EPSDT participants ages two (2) weeks to two (2) years will receive at least one (1) of their periodic or interperiodic screens annually from a physician, NP, or PA, unless otherwise medically indicated. A parent or guardian may choose to waive the requirement for a physician, NP, or PA, to perform the screen. EPSDT RN screeners will refer participants for further evaluation, diagnosis, and treatment to appropriate services such as physician, registered dietitian, developmental evaluation, speech, hearing, and vision evaluation, and blood lead level evaluation. Efforts will be made to assure that routine screening will not be duplicated for children who receive primary care services from a physician. (7-1-06)T

584. CHILD WELLNESS SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

01. Interperiodic Medical Screens. Interperiod medical screens must be performed by a physician, NP, or PA. (7-1-06)T

02. Periodic Medical Screens. Periodic medical screens can be performed by a physician, NP, PA, or a Registered Nurse Screener. (7-1-06)T

03. EPSDT Registered Nurse Screener. A licensed professional nurse (RN) who is currently licensed to practice in Idaho, and who meets the following provisions: (7-1-06)T

a. Training Requirements. Can produce proof of completion of the Medicaid Child Health Assessment training course (or equivalent as approved by Medicaid) that: (7-1-06)T

i. Prepares the RN to identify the difference between screening, diagnosis, and

treatment and prepares the RN to appropriately screen and differentiate between normal and abnormal findings. (7-1-06)T

ii. Includes at least five (5) days of didactic instruction in child health assessment, accompanied by a component of supervised clinical practice. (7-1-06)T

b. Linkage to Primary Care Services. Is employed by a physician, district health department, rural health clinic, Indian Health Clinic, or Federally Qualified Health Center (FQHC) in order to provide linkage to primary care services. The employers must have a signed Medicaid provider agreement and provider number. (7-1-06)T

c. Consultation. Has an established agreement with a physician or nurse practitioner for consultation on an as-needed basis. (7-1-06)T

585. -- 589. (RESERVED).

590. ADULT PHYSICALS.
Adult preventive physical examinations are limited to one (1) per year. (7-1-06)T

591. -- 601. (RESERVED).

602. SCREENING MAMMOGRAPHIES - COVERAGE AND LIMITATIONS.

01. Screening Mammographies. Screening mammographies are limited to one (1) per year for women who are forty (40) or more years of age. (7-1-06)T

02. Diagnostic Mammographies. Diagnostic mammographies are not subject to the limitations of screening mammographies. Diagnostic mammographies are covered when a physician orders the procedure for a participant of any age. (7-1-06)T

603. (RESERVED).

604. SCREENING MAMMOGRAPHIES - PROVIDER QUALIFICATIONS AND DUTIES.
Idaho Medicaid will cover screening or diagnostic mammographies performed with mammography equipment and staff considered certifiable or certified by the Bureau of Laboratories. (7-1-06)T

605. -- 609. (RESERVED).

610. CLINIC SERVICES - DIAGNOSTIC SCREENING CLINICS.
The Department will reimburse medical social service visits to clinics which coordinate the treatment between physicians and other medical professionals for participants which are diagnosed with cerebral palsy, myelomeningitis or other neurological diseases and injuries with comparable outcomes. (7-1-06)T

01. Multidisciplinary Assessments and Consultations. The clinic must perform on site multidisciplinary assessments and consultations with each participant and responsible parent

or guardian. Diagnostic and consultive services related to the diagnosis and treatment of the participant will be provided by board certified physician specialists in physical medicine, neurology and orthopedics. (7-1-06)T

02. Billings. No more than five (5) hours of medical social services per participant may be billed by the specialty clinic each state fiscal year for which the medical social worker monitors and arranges participant treatments and provides medical information to providers which have agreed to coordinate the care of their participant. (7-1-06)T

03. Services Performed. Services performed or arranged by the clinic will be subject to the amount, scope and duration for each service as set forth elsewhere in this chapter. (7-1-06)T

04. The Clinic. The clinic is established as a separate and distinct entity from the hospital, physician or other provider practices. (7-1-06)T

611. -- 614. (RESERVED).

615. ADDITIONAL ASSESSMENT AND EVALUATION SERVICES.
In addition to evaluations for services as defined in this Chapter, the Department will reimburse for the following evaluations if needed to determine eligibility for Medicaid Enhanced Plan Benefits. (7-1-06)T

01. Enhanced Mental Health Services. Enhanced mental health services are not ~~a~~ covered ~~*service*~~ under the Basic Plan with the exception of assessment services. The assessment for determination of need for Enhanced mental health services ~~*are*~~ *is* subject to the requirements for comprehensive assessments at IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," S~~*ubs*~~ection 113, and provider qualifications under Section 71~~*4*~~*5* of these rules and under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 130 and 131. ~~*(7-1-06)T*~~(7-1-06)T

02. Developmental Disability Agency Services (DDA). DDA services are not ~~a~~ covered ~~*service*~~ under the Basic Plan with the exception of assessment and evaluation services. The assessment and/or evaluation for the need for DDA services ~~*are*~~ *is* subject to the requirements for DDA services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 653.02, and IDAPA 16.04.11, "Developmental Disabilities Agencies," Sections 600 through 604. ~~*(7-1-06)T*~~(7-1-06)T

03. Service Coordination Services. Service coordination services are not ~~a~~ covered ~~*services*~~ under the Basic Plan, with the exception of assessment services. The assessment for the need for service coordination services ~~*are*~~ *is* subject to the requirements for service coordination under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 727.03, as applicable to the service being requested, and provider qualifications under IDAPA 10.03.10, "Medicaid Enhanced Plan Benefits," Section 729. ~~*(7-1-06)T*~~(7-1-06)T

616. -- 619. (RESERVED).

620. ~~*PREVENTION AND*~~ *PREVENTIVE* HEALTH ASSISTANCE (PHA) - *DEFINITIONS*.

~~Prevention and health assistance (PHA) benefits are made available to participants who use tobacco or are obese, for the purposes of supporting tobacco cessation or weight loss. Participants must meet Department-defined criteria for PHA eligibility and use. (7-1-06)T~~

01. Behavioral PHA. Benefits available to a participant specifically to support tobacco cessation or weight control. (12-1-06)T

02. Benefit Year. A benefit year is twelve (12) continuous months. A participant's PHA benefit year begins the date his initial points are earned. (12-1-06)T

03. PHA Benefit. A mechanism to reward healthy behaviors and good health choices of a participant eligible for preventive health assistance. (12-1-06)T

04. Wellness PHA. Benefits available to a participant to support wellness and safety. (12-1-06)T

621. PREVENTIVE HEALTH ASSISTANCE (PHA) - PARTICIPANT ELIGIBILITY.

01. Behavioral PHA. The participant must have a Health Questionnaire on file with the Department. The Health Questionnaire is used to determine eligibility for a Behavioral PHA. The participant must indicate on the Health Questionnaire that he wants to change a behavior related to weight management or tobacco cessation. The participant must meet one of the following criteria: (12-1-06)T

a. For an adult, a body mass index (BMI) of thirty (30) or higher or eighteen and one-half (18 1/2) or lower. (12-1-06)T

b. For a child, a body mass index (BMI) that falls in either the overweight or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. (12-1-06)T

c. For either an adult or a child, use of tobacco products. (12-1-06)T

02. Wellness PHA. A participant who is required to pay premiums to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children," is eligible for Wellness PHA. (12-1-06)T

622. PREVENTIVE HEALTH ASSISTANCE (PHA) - COVERAGE AND LIMITATIONS.

01. Point System. The PHA benefit uses a point system to track points earned and used by a participant. Points earned by a participant can be exchanged for a voucher to purchase products or services as specified in Subsections 622.02 through 622.06 of this rule. Each point equals one (1) dollar. (12-1-06)T

a. Maximum Benefit Points. (12-1-06)T

i. The maximum number of points that can be earned for a Behavioral PHA is two hundred (200) points each benefit year. (12-1-06)T

ii. The maximum number of points that can be earned for a Wellness PHA benefit is one hundred twenty (120) points each benefit year. *(12-1-06)T*

iii. The total maximum number of points that can be earned by a participant who has both a Behavioral and a Wellness PHA is two hundred (200) points each benefit year. *(12-1-06)T*

b. *Each participant is limited to one (1) Behavioral PHA benefit at any point in time.* *(12-1-06)T*

c. *Points expire and are removed from a participant's PHA benefit at the end of the participant's benefit year.* *(12-1-06)T*

d. *Points earned for a specific participant's PHA benefit cannot be transferred to or combined with points in another participant's PHA benefit.* *(12-1-06)T*

02. Medications and Pharmaceutical Supplies*. Medications and pharmaceutical supplies must be purchased from a licensed pharmacy.* *(12-1-06)T*

a. *Each medication and pharmaceutical supply must have a primary purpose directly related to weight management or tobacco cessation.* *(12-1-06)T*

b. *Each medication and pharmaceutical supply must be approved by the FDA, or specifically recommended by the participant's PCP, or a referred physician specialist.* *(12-1-06)T*

03. Sporting or Fitness Program*.* *(12-1-06)T*

a. *Each program must emphasize safety and improved physical health.* *(12-1-06)T*

b. *Each program must be approved by any and all applicable regulatory bodies.* *(12-1-06)T*

04. Sports Safety Equipment*. Each piece of sports safety equipment must afford protection or otherwise support safe participation in a sport with an expected outcome of improved physical health, and meet any and all established, applicable independent standards related to the product.* *(12-1-06)T*

05. Weight Management Program*. Each program must provide weight management services and must include a curriculum that includes at least one (1) of the three (3) following areas:* *(12-1-06)T*

a. *Physical fitness;* *(12-1-06)T*

b. *Balanced diet; or* *(12-1-06)T*

c. *Personal health education.* *(12-1-06)T*

06. Participant Request for Coverage*. A participant can request that a previously*

unidentified product or service be covered. The Department will approve a request if the product or service meets the requirements described in this section of rule and the vendor meets the requirements in Section 624 of these rules. *(12-1-06)T*

07. Premiums. *(12-1-06)T*

a. PHA benefit points must be used to pay a participant's delinquent premiums, if any, before a voucher can be issued for products or services. (12-1-06)T

b. Only premiums that must be paid to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children" can be offset by PHA benefit points. (12-1-06)T

08. Hearing Rights. *A participant does not have hearing rights for issues arising between the participant and a chosen vendor.* *(12-1-06)T*

623. PREVENTIVE HEALTH ASSISTANCE (PHA) - PROCEDURAL REQUIREMENTS.

01. Behavioral PHA. *(12-1-06)T*

a. *A PHA benefit will be established for each participant who meets the eligibility criteria for Behavioral PHA. A participant must complete a PHA Benefit Agreement Form prior to earning any points.* *(12-1-06)T*

b. *Each participant who chooses a goal of tobacco cessation must enroll in a tobacco cessation program.* *(12-1-06)T*

c. *Each participant who chooses a goal of weight management must participate in a physician approved or monitored weight management program.* *(12-1-06)T*

d. *An initial one hundred (100) points are earned when the agreement form is received by the Department and the benefit is established.* *(12-1-06)T*

e. *An additional one hundred (100) points can be earned by a participant who completes his program or reaches a chosen, defined goal. The vendor monitoring the participant's progress must verify that the program was completed or the goal was reached.* *(12-1-06)T*

02. Wellness PHA. *(12-1-06)T*

a. *A PHA benefit will be established for each participant who meets the eligibility criteria for Wellness PHA. Each participant must demonstrate that he has received recommended wellness visits and immunizations for his age prior to earning any points.* *(12-1-06)T*

b. *An initial thirty (30) points are earned when the benefit is established.* *(12-1-06)T*

c. *An additional thirty (30) points can be earned each quarter by a participant who receives all recommended wellness visits and immunizations for his age during the benefit year.* *(12-1-06)T*

03. Vouchers. *The participant must contact the Department to request a voucher to purchase selected products or services. The participant must deliver the voucher to the vendor prior to receiving products or services.* *(12-1-06)T*

04. Approved Products and Services. *The reimbursable products and services of each vendor must be prior approved by the Department.* *(12-1-06)T*

624. PREVENTIVE HEALTH ASSISTANCE (PHA) - PROVIDER QUALIFICATIONS AND DUTIES.

01. Voucher Acceptance. *Each vendor must be willing to accept PHA vouchers and bill the Department for reimbursement.* *(12-1-06)T*

02. Voucher Expiration. *The vendor must accept a voucher prior to the expiration date printed on the voucher.* *(12-1-06)T*

03. Provider Agreement. *A voucher signed by a vendor and presented to the Department for reimbursement constitutes a fully-executed provider agreement.* *(12-1-06)T*

04. Medications and Pharmaceutical Supplies Vendor. *Each vendor must be a licensed pharmacy.* *(12-1-06)T*

05. Sporting or Fitness Program Vendor. *Each vendor must be able to provide a sporting or fitness program as described in Section 622 of these rules.* *(12-1-06)T*

06. Sports Safety Equipment Vendor. *(12-1-06)T*

a. *Each vendor must be established as a business serving the general public that provides sports safety equipment.* *(12-1-06)T*

b. *Each vendor must meets all state, county, and local business licensing requirements.* *(12-1-06)T*

c. *Each vendor must be able to provide sports safety equipment as described in Section 622 of these rules.* *(12-1-06)T*

07. Weight Management Program Vendor. *(12-1-06)T*

a. *Each vendor must be established as a business that serves the general public.* *(12-1-06)T*

b. *Each vendor must meet all state, county, and local business licensing requirements.* *(12-1-06)T*

c. *Each vendor must be able to provide a weight management program as described in Section 622 of these rules.* *(12-1-06)T*

625. PREVENTIVE HEALTH ASSISTANCE (PHA) - PROVIDER REIMBURSEMENT.

***01. Voucher Must Be Signed**. The Department, the participant, and the vendor must sign each PHA voucher for which a vendor requests reimbursement. (12-1-06)T*

***02. Voucher Amount**. The vendor must agree to accept the amount stated on each PHA voucher as full or partial payment of approved products and services. (12-1-06)T*

***03. Voucher Redemption**. Each voucher must be redeemed by the vendor within ninety (90) days of providing the product or service to the participant. (12-1-06)T*

626. PREVENTIVE HEALTH ASSISTANCE (PHA) - QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of PHA. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. (12-1-06)T

62~~1~~7. -- 629. (RESERVED).

630. NUTRITIONAL SERVICES - DEFINITIONS.
Nutritional services include intensive nutritional education, counseling, and monitoring.
‘ (7-1-06)T

631. NUTRITIONAL SERVICES - PARTICIPANT ELIGIBILITY.
Nutritional services are only available to a participant who is a child or a pregnant woman. (7-1-06)T

632. NUTRITIONAL SERVICES - COVERAGE AND LIMITATIONS.

01. Physician Referral. The need for nutritional services must be discovered by the screening services and ordered by the physician. (7-1-06)T

02. Medically Necessary. The services must be medically necessary. (7-1-06)T

633. NUTRITIONAL SERVICES - PROCEDURAL REQUIREMENTS.
If over two (2) nutritional services visits per year are needed, they must be authorized by the Department prior to the delivery of additional visits. (7-1-06)T

634. NUTRITIONAL SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
Nutritional services must be performed by a registered dietician or an individual who has a baccalaureate degree from a U.S. regionally accredited college or university and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association. (7-1-06)T

635. NUTRITIONAL SERVICES - PROVIDER REIMBURSEMENT.
Payment for nutritional services is made at a rate established in accordance with Section 230 of these rules. (7-1-06)T

636. -- 639. (RESERVED).

640. DIABETES EDUCATION AND TRAINING SERVICES - DEFINITIONS.
For purposes of these rules, a Certified Diabetes Educator is a state-licensed health professional who is identified as a Certified Diabetes Educator according to the national standards of the National Certification Board for Diabetes Educators. (7-1-06)T

641. DIABETES EDUCATION AND TRAINING SERVICES - PARTICIPANT ELIGIBILITY.
The medical necessity for diabetes education and training are evidenced by the following: (7-1-06)T

01. Recent Diagnosis. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or (7-1-06)T

02. Uncontrolled Diabetes. Uncontrolled diabetes manifested by two (2) or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or (7-1-06)T

03. Recent Manifestations. Recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. (7-1-06)T

642. DIABETES EDUCATION AND TRAINING SERVICES - COVERAGE AND LIMITATIONS.

01. Concurrent Diagnosis. Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each participant's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. (7-1-06)T

02. No Substitutions. The physician may not use the formally structured program, or a Certified Diabetes Educator, as a substitute for basic diabetic care and instruction the physician must furnish to the participant, which includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of oral hypoglycemic agents. (7-1-06)T

03. Services Limited. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. (7-1-06)T

643. DIABETES EDUCATION AND TRAINING SERVICES - PROCEDURAL REQUIREMENTS.
To receive diabetes counseling, the participant must have a written order from the primary care provider who referred the participant to the program. (7-1-06)T

644. DIABETES EDUCATION AND TRAINING SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
Outpatient diabetes education and training services will be covered under the following conditions: (7-1-06)T

01. Meets Program Standards of the ADA. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association. (7-1-06)T

02. Conducted by a Certified Diabetic Educator. The education and training services are provided by a Certified Diabetic Educator through a formal program conducted in a hospital outpatient department, or in a physician's office. (7-1-06)T

645. DIABETES EDUCATION AND TRAINING SERVICES - PROVIDER REIMBURSEMENT.
Diabetes education and training services will be reimbursed according to the Department's established fee schedule in accordance with Section 230 of these rules. (7-1-06)T

646. -- 649. (RESERVED).

SUB AREA G: Laboratory And Radiology Services
(Sections 650 Through 659)

650. LABORATORY AND RADIOLOGY SERVICES - DEFINITIONS.

01. Independent Laboratory. A laboratory that is not located in a physician's office. (7-1-06)T

02. Reference Laboratory. A laboratory that only accepts specimens from other laboratories and does not receive specimens directly from patients. (7-1-06)T

651. -- 653. (RESERVED).

654. LABORATORY AND RADIOLOGY SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
Laboratories in a physician's office or a physician's group practice association, except when physicians personally perform their own patients' laboratory tests, must be certified by the Idaho Bureau of Laboratories and be eligible for Medicare certification for participation. All other Idaho laboratories must fulfill these requirements. (7-1-06)T

655. LABORATORY AND RADIOLOGY SERVICES - PROVIDER REIMBURSEMENT.
Payment for laboratory tests can only be made to the actual provider of that service. An exception to the preceding is made in the case of an independent laboratory that can bill for a reference laboratory. A physician is not an independent laboratory. (7-1-06)T

01. Tests Performed by or Personally Supervised by a Physician. The payment level for clinical diagnostic laboratory tests performed by or personally supervised by a physician will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be a rate established by the Department. (7-1-06)T

02. Tests Performed by an Independent Laboratory. The payment level for clinical diagnostic laboratory tests performed by an independent laboratory will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (7-1-06)T

03. Tests Performed by a Hospital Laboratory. The payment level for clinical diagnostic laboratory tests performed by a hospital laboratory for anyone who is not an inpatient will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (7-1-06)T

04. Specimen Collection Fee. Collection fees for specimens drawn by veinpuncture or catheterization are payable only to the physician or laboratory who draws the specimen. (7-1-06)T

656. -- 659. (RESERVED).

SUB AREA H: PRESCRIPTION DRUGS
(Sections 660 Through 679)

660. (RESERVED).

661. PRESCRIPTION DRUGS - PARTICIPANT ELIGIBILITY.

01. Obtaining a Prescription Drug. To obtain a prescription drug, a Medicaid participant or authorized agent must present the participant's Medicaid identification card to a participating pharmacy together with a prescription from a licensed prescriber. (7-1-06)T

02. Drug Coverage for Dual Eligibles. For Medicaid participants who are also eligible for Medicare ("dual eligibles"), the Department will pay for Medicaid-covered drugs that are not covered by Medicare Part D. Dual eligibles will be subject to the same limits and processes used for any other Medicaid participants. (7-1-06)T

662. PRESCRIPTION DRUGS - COVERAGE AND LIMITATIONS.

01. General Drug Coverage. The Department will pay for those prescription drugs not excluded by Subsection 662.04 of these rules which are legally obtainable by the order of a licensed prescriber whose licensing allows for the prescribing of legend drugs, as defined under Section 54-1705(2~~7~~8), Idaho Code, and which are deemed medically necessary as defined in Section 011 of these rules. ~~(7-1-06)T~~(7-1-06)T

02. Dispensing Fee. Dispensing Fee is defined as the cost of filling a prescription

including direct pharmacy overhead and is one (1) of two (2) types: (7-1-06)T

a. Regular Dose Fee. For services pertaining to the usual practice of pharmacy, including but not limited to: (7-1-06)T

i. Interpretation, evaluation, compounding, and dispensing of prescription drug orders; (7-1-06)T

ii. Participation in drug selection; (7-1-06)T

iii. Drug administration; (7-1-06)T

iv. Drug regimen and research reviews; (7-1-06)T

v. Proper storage of drugs; (7-1-06)T

vi. Maintenance of proper records; (7-1-06)T

vii. Prescriber interaction; and (7-1-06)T

viii. Patient counseling. (7-1-06)T

b. Unit Dose Fee. Unit-dose dispensing is defined as a system of providing individually sealed and appropriately labeled unit dose medication that ensures no more than a twenty-four (24) hour supply in any participant's drug tray at any given time. These drug trays, which contain a twenty-four (24) hour supply of medication, must be delivered to the facility at a minimum of five (5) days per week. (7-1-06)T

03. Limitations on Payment. Medicaid payment for prescription drugs will be limited as follows: (7-1-06)T

a. Days' Supply. Medicaid will not cover any days' supply of prescription drugs that exceeds the quantity or dosage allowed by these rules. (7-1-06)T

b. Brand Name Drugs. Medicaid will not pay for a brand name product that is part of the federal upper limit (FUL) or state maximum allowable cost (SMAC) listing when the physician has not specified the brand name drug to be medically necessary. (7-1-06)T

c. Medication for Multiple Persons. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for the person or persons covered by Medicaid. (7-1-06)T

d. No Prior Authorization. Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in Section 663 of these rules. (7-1-06)T

e. Limitations to Discourage Waste. Medicaid may conduct drug utilization reviews and impose limitations for participants whose drug utilization exceeds the standard participant

profile or disease management guidelines determined by the Department. (7-1-06)T

04. Excluded Drug Products. The following categories and specific products are excluded from coverage by Medicaid: (7-1-06)T

a. Non-Legend Medications. Federal legend medications that change to non-legend status, as well as their therapeutic equivalents regardless of prescription, status unless: (7-1-06)T

i. They are included in Subsection 662.05.b. of these rules; or (7-1-06)T

ii. The Director determines that non-legend drug products are covered based upon appropriate criteria including the following: safety, effectiveness, clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, cost, and the recommendation of the Pharmacy And Therapeutics Committee. Therapeutically interchangeable is defined in Subsection 663.01.e. of these rules. (7-1-06)T

b. Legend Drugs. Any legend drugs for which federal financial participation is not available. (7-1-06)T

c. Diet Supplements. Diet supplements and weight loss products, except lipase inhibitors when prior authorized as outlined in Section 663 of these rules. (7-1-06)T

d. Amphetamines and Related Products. Amphetamines and related products for cosmetic purposes or weight loss. Amphetamines and related products which are deemed to be medically necessary may be covered if prior authorized as outlined in Section 663 of these rules. (7-1-06)T

e. Ovulation/Fertility Drugs. Ovulation stimulants, fertility drugs, and similar products. (7-1-06)T

f. Impotency Aids. Impotency aids, either as medication or prosthesis. (7-1-06)T

g. ~~*Nicotine*~~ *Tobacco Cessation* Products. Nicotine chewing gum, sprays, inhalers, transdermal patches and related products. ~~*(7-1-06)T*~~(7-1-06)T

h. Medications Utilized for Cosmetic Purposes. Medications utilized for cosmetic purposes or hair growth. Prior authorization may be granted for these medications if the Department finds other medically necessary indications. (7-1-06)T

i. Vitamins. Vitamins unless included in Subsection 662.05.a. of these rules. (7-1-06)T

j. Dual Eligibles. Drug classes covered under Medicare, Part D, for Medicaid participants who are also eligible for Medicare. (7-1-06)T

05. Additional Covered Drug Products. Additional drug products will be allowed as follows: (7-1-06)T

a. Therapeutic Vitamins. Therapeutic vitamins may include: (7-1-06)T

i. Injectable vitamin B12 (cyanocobalamin and analogues); (7-1-06)T

ii. Vitamin K and analogues; (7-1-06)T

iii. Pediatric legend vitamin-fluoride preparations; (7-1-06)T

iv. Legend prenatal vitamins for pregnant or lactating women; (7-1-06)T

v. Legend folic acid; (7-1-06)T

vi. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and (7-1-06)T

vii. Legend vitamin D and analogues. (7-1-06)T

b. Prescriptions for Nonlegend Products. Prescriptions for nonlegend products may include: (7-1-06)T

i. Insulin; (7-1-06)T

ii. Disposable insulin syringes and needles; (7-1-06)T

iii. Oral iron salts; and (7-1-06)T

iv. Permethrin. (7-1-06)T

06. Limitation of Quantities. Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: (7-1-06)T

a. Doses of Medication. Up to one hundred (100) doses of medication may be dispensed, not to exceed a one hundred (100) day supply for: (7-1-06)T

i. Cardiac glycosides; (7-1-06)T

ii. Thyroid replacement hormones; (7-1-06)T

iii. Prenatal vitamins; (7-1-06)T

iv. Nitroglycerin products - oral or sublingual; (7-1-06)T

v. Fluoride and vitamin/fluoride combination products; and (7-1-06)T

vi. Nonlegend oral iron salts. (7-1-06)T

b. Oral Contraceptive Products. Oral contraceptive products may be dispensed in a quantity sufficient for one (1), two (2), or three (3) cycles. (7-1-06)T

663. PRESCRIPTION DRUGS - PROCEDURAL REQUIREMENTS.

01. Items Requiring Prior Authorization. Pharmaceutical items requiring prior authorization include: (7-1-06)T

a. Amphetamines and related CNS stimulants; (7-1-06)T

b. Growth hormones; (7-1-06)T

c. Retinoids; (7-1-06)T

d. Brand name drugs when an acceptable generic form exists; (7-1-06)T

e. Medication otherwise covered by the Department for which there is a therapeutically interchangeable alternate medication identified by the Department. Therapeutically interchangeable means a medication that is interchangeable with another medication within the same pharmacologic or therapeutic class and is at least as effective as the medication for which it is being interchanged. The Director may exempt a drug from the prior authorization requirement described in Section 663 of this chapter of rules, based upon appropriate criteria, including the following: safety, effectiveness, clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, cost, and the recommendation of the Pharmacy And Therapeutics Committee (P&T Committee). The Department determines, and will make available to providers, which drugs are therapeutically interchangeable using a number of resources that may include: (7-1-06)T

i. Peer-reviewed medical literature; (7-1-06)T

ii. Randomized clinical trials; (7-1-06)T

iii. Drug comparison studies; (7-1-06)T

iv. Pharmacoeconomic studies; (7-1-06)T

v. Outcomes research data; (7-1-06)T

vi. Idaho practice guidelines; and (7-1-06)T

vii. Consultation with practicing physicians, pharmacists, and the Idaho Medicaid Medical Director. (7-1-06)T

f. Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines. (7-1-06)T

g. Lipase inhibitors. (7-1-06)T

h. Medications prescribed outside of the Food and Drug Administration approved indications. (7-1-06)T

i. Medications excluded in Subsection 662.04 of these rules that the Department accepts for other medically-approved indications. (7-1-06)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. (7-1-06)T

03. Notice of Decision. The Department will determine coverage based on this request, and will notify the participant of a denial. (7-1-06)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 U.S.C 1396r-8(d)(5)(B). (7-1-06)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 U.S.C 1396r-8(d)(5)(A). (7-1-06)T

06. Supplemental Rebates. (7-1-06)T

a. Purpose. The purpose of supplemental rebates is to enable the Department to purchase prescription drugs provided to Medicaid participants 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. (7-1-06)T

b. Rebate Amount. The Department 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. (7-1-06)T

07. Comparative Costs to be Considered. Whenever possible, physicians and pharmacists are encouraged to utilize less expensive drugs and drug therapies. (7-1-06)T

664. PRESCRIPTION DRUGS - PROVIDER QUALIFICATIONS AND DUTIES.

01. Payment for Covered Drugs. Payment will be made, as provided in Section 665 of these rules, only to pharmacies registered with the Department as a provider for the specific location where the service was performed. An out of the state pharmacy shipping or mailing a prescription into Idaho must have a valid mail order license issued by the Idaho Board of Pharmacy and be properly enrolled as a Medicaid provider. (7-1-06)T

02. Dispensing Procedures. The following protocol must be followed for proper prescription filling. (7-1-06)T

a. Prescription Drug Refills. Refills of prescription drugs must be authorized by the prescriber on the original or new prescription order on file and each refill must be recorded on the prescription or logbook, or computer print-out, or on the participant's medication profile. (7-1-06)T

b. Dispensing Prescription Drugs. Prescriptions must be dispensed according to: (7-1-06)T

i. 21 CFR Section 1300, et seq.; (7-1-06)T

ii. Title 54, Chapter 17, and Title 37, Chapter 1, 27, and 32, Idaho Code; (7-1-06)T

iii. IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy"; (7-1-06)T

iv. Sections 660 through 666 of these rules. (7-1-06)T

c. Prescriptions on File. Prescriptions must be maintained on file in pharmacies in such a manner that they are available for immediate review by the Department upon written request . (7-1-06)T

03. Return of Unused *Prescription* Drugs. *When prescription drugs were dispensed in unit dose packaging, as defined by IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05, and the participant for whom the drugs were prescribed no longer uses them:* ~~(7-1-06)T~~*(7-1-06)T*

a. A licensed skilled nursing care facility ~~*must*~~ *may* return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. ~~(7-1-06)T~~(7-1-06)T

b. A residential or assisted living facility may return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. (7-1-06)T

04. Pharmacy Provider Receiving Unused Prescription Drugs*. In order for a pharmacy provider to receive unused prescription drugs that it dispensed in unit dose packaging and that are being returned by a facility identified in Subsection 664.03 of this rule, the pharmacy provider: (7-1-06)T*

a. *Must comply with IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05, regarding unit dose packaging; (7-1-06)T*

b. *Must credit the Department the amount billed for the cost of the drug less the dispensing fee; and (7-1-06)T*

c. *May receive a fee for acceptance of returned unused prescription drugs. The value of the unused prescription drug being returned must be such that return of the drug is cost-effective as determined by the Department. (7-1-06)T*

665. PRESCRIPTION DRUGS - PROVIDER REIMBURSEMENT.

01. Nonpayment of Prescriptions. Prescriptions not filled in accordance with the provisions of Subsection 664.02 of these rules will be subject to nonpayment or recoupment. (7-1-06)T

02. Payment Procedures. The following protocol must be followed for proper reimbursement. (7-1-06)T

a. Filing Claims. Pharmacists must file claims electronically with Department-approved software or by submitting the appropriate claim form to the fiscal contractor. Upon request, the contractor will provide pharmacies with a supply of claim forms. The form must include information described in the pharmacy guidelines issued by the Department. (7-1-06)T

b. Claim Form Review. Each claim form may be subject to review by a contract claim examiner, a pharmaceutical consultant, or a medical consultant. (7-1-06)T

c. Billed Charges. A pharmacy's billed charges are not to exceed the usual and customary charges defined as the lowest charge by the provider to the general public for the same service including advertised specials. (7-1-06)T

d. Reimbursement. Reimbursement to pharmacies is limited to the lowest of the following: (7-1-06)T

i. Federal Upper Limit (FUL), as established by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; 7-1-06)T

ii. State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned dispensing fee; (7-1-06)T

iii. Estimated Acquisition Cost (EAC), as established by the Department following negotiations with representatives of the Idaho pharmacy profession defined as an approximation of the net cost of the drug and a reasonable operating margin, plus the assigned dispensing fee; or (7-1-06)T

iv. The pharmacy's usual and customary charge to the general public as defined in Subsection 665.02.c. of this rule. (7-1-06)T

e. Dispensing Fees. Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: (7-1-06)T

i. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (7-1-06)T

ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (7-1-06)T

iii. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (7-1-06)T

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (7-1-06)T

f. Remittance Advice. Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic claims transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (7-1-06)T

g. Return of Drugs. Drugs dispensed in unit dose packaging as defined by IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05, must be returned to the dispensing pharmacy when the participant no longer uses the medication as follows: (7-1-06)T

i. A pharmacy provider using unit dose packaging must comply with IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05. (7-1-06)T

ii. The pharmacy provider that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the dispensing fee. (7-1-06)T

iii. The pharmacy provider may receive a fee for acceptance of returned unused drugs. The value of the unused drug being returned must be cost effective as determined by the Department. (7-1-06)T

666. PRESCRIPTION DRUGS - QUALITY ASSURANCE.

01. Pharmacy And Therapeutics Committee (P&T Committee).

a. 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. (7-1-06)T

b. Function. The P&T Committee has the following responsibilities for the prior authorization of drugs under Section 663 of these rules: (7-1-06)T

i. To serve in evaluational, educational and advisory capacities to the Idaho Medicaid Program specific to the prior authorization of drugs with therapeutically interchangeable alternatives. (7-1-06)T

ii. 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. (7-1-06)T

iii. To recommend to the Department the classes of medications to be reviewed through evidence-based evaluation. (7-1-06)T

iv. 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. (7-1-06)T

c. 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: (7-1-06)T

i. 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 (7-1-06)T

ii. Participant-specific or provider-specific information. (7-1-06)T

667. -- 679. (RESERVED).

SUB AREA I: Family Planning
(Sections 680 Through 699)

680. (RESERVED).

681. FAMILY PLANNING SERVICES - PARTICIPANT ELIGIBILITY.

01. Sterilization Procedures -- General Restrictions. The following restrictions govern payment for sterilization procedures for eligible persons. (7-1-06)T

a. No sterilization procedures will be paid on behalf of a participant who is not at least twenty-one (21) years of age at the time he or she signs the informed consent. (7-1-06)T

b. No sterilization procedures will be paid on behalf of any participant who is twenty-one (21) years of age or over and who is incapable of giving informed consent. (7-1-06)T

c. Each participant must voluntarily sign the properly completed "Consent Form" HW 0034, or its equivalent, in the presence of the person obtaining consent in accordance with Section 683 of these rules. (7-1-06)T

d. Each participant must sign the "Consent Form" at least thirty (30) days but not more than one hundred eighty (180) days, prior to the sterilization procedures. Exceptions to these time requirements are described under Subsection 682.03 of these rules. (7-1-06)T

02. Circumstances Under Which Payment Can be Made for a Hysterectomy. Payment can be made for a hysterectomy only if: (7-1-06)T

a. It is medically necessary. A document must be attached to the claim to substantiate this requirement; and (7-1-06)T

b. There was more than one (1) purpose in performing the hysterectomy, and the hysterectomy would not have been performed for the sole purpose of rendering an individual permanently incapable of reproducing; and (7-1-06)T

c. The participant was advised orally and in writing that sterility would result and that she would no longer be able to bear children; and (7-1-06)T

d. The participant signs and dates an "Authorization for Hysterectomy" form. The form must state "I have been informed orally and in writing that a hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed". (7-1-06)T

682. FAMILY PLANNING SERVICES - COVERAGE AND LIMITATIONS.
Family planning includes counseling and medical services prescribed or performed by an independent licensed physician, or a qualified certified nurse practitioner or physician's assistant. Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization. (7-1-06)T

01. Contraceptive Supplies. (7-1-06)T

a. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. (7-1-06)T

b. Contraceptives requiring a prescription are payable subject to Section 662 of these rules. (7-1-06)T

c. Payment for oral contraceptives is limited to purchase of a three (3) month supply. (7-1-06)T

02. Sterilization. (7-1-06)T

a. No sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are eligible for payment unless such sterilizations are ordered by a court of law. (7-1-06)T

b. Hysterectomies performed solely for sterilization purposes are not eligible for payment (see Subsection 681.02 of these rules for those conditions under which a hysterectomy can be eligible for payment). (7-1-06)T

c. All requirements of state or local law for obtaining consent, except for spousal consent, must be followed. (7-1-06)T

d. Suitable arrangements must be made to insure that information as specified in Subsection 681.01 of these rules is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise handicapped. (7-1-06)T

03. Exceptions to Sterilization Time Requirements. If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the participant's signature on the consent form; and (7-1-06)T

a. In the case of premature delivery, the physician must also state the expected date of delivery and describe the emergency in detail; and (7-1-06)T

b. Describe, in writing to the Department, the nature of any emergency necessitating emergency abdominal surgery; and (7-1-06)T

c. Under no circumstance can the period between consent and sterilization exceed one hundred eighty (180) days. (7-1-06)T

04. Requirements for Sterilization Performed Due to a Court Order. When a sterilization is performed after a court order is issued, the physician performing the sterilization must have been provided with a copy of the court order prior to the performance of the sterilization. In addition he must: (7-1-06)T

a. Certify, by signing a properly completed "Consent Form" HW 0034, or its equivalent, and submitting the consent form with his claim, that all requirements have been met concerning sterilizations; and (7-1-06)T

b. Submit to the Department a copy of the court order together with the "Consent Form" and claim. (7-1-06)T

683. FAMILY PLANNING SERVICES - PROCEDURAL REQUIREMENTS.

01. Sterilization Consent Form Requirements. Informed consent exists when a properly completed "Consent Form" HW 0034, or its equivalent, is submitted to the Department together with the physician's claim for the sterilization. (7-1-06)T

a. The consent form must be signed and dated by: (7-1-06)T

i. The participant to be sterilized; and (7-1-06)T

ii. The interpreter, if one (1) is provided; and (7-1-06)T

iii. The individual who obtains the consent; and (7-1-06)T

iv. The physician who will perform the sterilization procedure. (7-1-06)T

v. If the individual obtaining the consent and the physician who will perform the sterilization procedure are the same person, that person must sign both statements on the consent form. (7-1-06)T

b. Informed consent must not be obtained while the participant in question is: (7-1-06)T

i. In labor or childbirth; or (7-1-06)T

ii. Seeking to obtain or obtaining an abortion; or (7-1-06)T

iii. Under the influence of alcohol or other substances that affect the individual's state of awareness. (7-1-06)T

c. An interpreter must be provided if the participant does not understand the language used on the consent form or the language used by the person obtaining the consent. (7-1-06)T

d. The person obtaining consent must: (7-1-06)T

i. Offer to answer any questions the participant may have concerning the procedure; and (7-1-06)T

ii. Orally advise the participant that he is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting his right to future care or treatment, and without loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled; and (7-1-06)T

iii. Provide a description of available alternative methods of family planning and birth control; and (7-1-06)T

iv. Orally advise the participant that the sterilization procedure is considered to be irreversible; and (7-1-06)T

v. Provide a thorough explanation of the specific sterilization procedure to be performed; and (7-1-06)T

vi. Provide a full description of the discomfort and risks that may accompany and follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used; and (7-1-06)T

vii. Provide a full description of the benefits or advantages that can be expected as a result of the sterilization; and (7-1-06)T

viii. Advise that the sterilization procedure will not be performed for at least thirty (30) days except under extreme circumstances as specified in Subsection 682.03 of these rules. (7-1-06)T

e. The person securing the consent from the participant must certify by signing the

"Consent Form" that: (7-1-06)T

i. Before the participant signed the consent form, he or she was advised that no federal benefits would be withheld because of the decision to be or not to be sterilized; and (7-1-06)T

ii. The requirements for informed consent as set forth on the consent form were orally explained; and (7-1-06)T

iii. To the best of his knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization. (7-1-06)T

f. The physician performing the sterilization must certify by signing the "Consent Form" that: (7-1-06)T

i. At least thirty (30) days have passed between the participant's signature on that form and the date the sterilization was performed; and (7-1-06)T

ii. To the best of the physician's knowledge the participant is at least twenty-one (21) years of age; and (7-1-06)T

iii. Before the performance of the sterilization the physician advised the participant that no federal benefits will be withdrawn because of the decision to be or not to be sterilized; and (7-1-06)T

iv. The physician explained orally the requirement for informed consent as set forth in the "Consent Form"; and (7-1-06)T

v. To the best of his knowledge and belief the participant to be sterilized appeared mentally competent and knowingly and voluntarily consented to the sterilization. (7-1-06)T

g. If an interpreter is provided, he must certify by signing the "Consent Form" that: (7-1-06)T

i. He accurately translated the information and advice presented orally to the participant; and (7-1-06)T

ii. He read the "Consent Form" and accurately explained its contents; and (7-1-06)T

iii. To the best of his knowledge and belief, the participant understood the interpreter. (7-1-06)T

h. The person obtaining consent must sign the "Consent Form" and certify that he or she has fulfilled specific requirements in obtaining the participant's consent. (7-1-06)T

i. The physician who performs the sterilization must sign the "Consent Form" HW 0034, certifying that the requirements of Section 683 of this chapter of rules have been fulfilled. (7-1-06)T

684. (RESERVED).

685. FAMILY PLANNING SERVICES - PROVIDER REIMBURSEMENT.
Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost. ~~*Payment for family planning services is made at a rate established in accordance with Section 230 of these rules.* *(7-1-06)T*~~(7-1-06)T

686. -- 699. (RESERVED).

SUB AREA J: MENTAL HEALTH SERVICES
(Sections 700 Through 719)

700. (RESERVED).

701. INPATIENT PSYCHIATRIC HOSPITAL SERVICES - PARTICIPANT ELIGIBILITY.
Participants must have a DSM IV diagnosis with substantial impairment in thought, mood, perception or behavior. (7-1-06)T

01. Medical Necessity Criteria. Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital. 7-1-06)T

a. Severity of illness criteria. The child must meet one (1) of the following criteria related to the severity of his psychiatric illness: (7-1-06)T

i. Is currently dangerous to self as indicated by at least one (1) of the following: (7-1-06)T

(1) Has actually made an attempt to take his own life in the last seventy-two (72) hours (details of the attempt must be documented); or (7-1-06)T

(2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or (7-1-06)T

(3) Has a clear plan to seriously harm himself, overt suicidal intent, and lethal means available to follow the plan (this information can be from the child or a reliable source and details of the child's plan must be documented); or (7-1-06)T

(4) A mental health professional has information from the child or a reliable source that the child has a current plan, specific intent, or recurrent thoughts to seriously harm himself and is at significant risk to making an attempt to carry out the plan without immediate intervention (details must be documented); or (7-1-06)T

ii. Child is actively violent or aggressive and exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others as indicated by one (1) of the

following: (7-1-06)T

(1) The child has actually engaged in behavior harmful or potentially harmful to others or caused serious damage to property which would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or (7-1-06)T

(2) The child has made threats to kill or seriously injure others or to cause serious damage to property which would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or (7-1-06)T

(3) A mental health professional has information from the child or a reliable source that the child has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or (7-1-06)T

iii. Child is gravely impaired as indicated by at least one (1) of the following criteria: (7-1-06)T

(1) The child has such limited functioning that his physical safety and well being are in jeopardy due to his inability for basic self-care, judgment and decision making (details of the functional limitations must be documented); or (7-1-06)T

(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child unmanageable and unable to cooperate in non-hospital treatment (details of the child's behaviors must be documented); or (7-1-06)T

(3) There is a need for treatment, evaluation or complex diagnostic testing where the child's level of functioning or communication precludes assessment and/or treatment in a non-hospital based setting, and may require close supervision of medication or behavior or both. (7-1-06)T

b. Intensity of service criteria. The child must meet all of the following criteria related to the intensity of services needed to treat his mental illness: (7-1-06)T

i. It is documented by the Regional Mental Health Authority that less restrictive services in the community do not exist or do not meet the treatment or diagnostic needs of the child, or the child has been unresponsive to treatment at a less intensive level of care. The services considered, tried, and/or needed must be documented; and (7-1-06)T

ii. The services provided in the hospital can reasonably be expected to improve the child's condition or prevent further regression so that inpatient services will no longer be needed; and (7-1-06)T

iii. Treatment of the child's psychiatric condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist. The child requiring this treatment must not be eligible for independent passes or unit passes

without observation or being accompanied by hospital personnel or a responsible other. (7-1-06)T

c. Exceptions. The requirement to meet intensity of service criteria may be waived for first time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the child is in his current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. (7-1-06)T

02. Exclusions. If a child meets one (1) or more of the following criteria, Medicaid reimbursement will be denied: (7-1-06)T

a. The child is unable to actively participate in an outpatient psychiatric treatment program solely because of a major medical condition, surgical illness or injury; or (7-1-06)T

b. The child demonstrates anti-social or criminal behavior or has criminal or legal charges against him and does not meet the severity of illness or intensity of service criteria; or (7-1-06)T

c. The child has anti-social behaviors or conduct problems that are a danger to others but are not attributable to a mental illness (DSM IV) with substantial impairment in thought, mood or perception; or (7-1-06)T

d. The child has a primary diagnosis of mental retardation and the primary treatment need is related to the mental retardation; or (7-1-06)T

e. The child lacks a place to live and/or family supports and does not meet severity of illness and intensity of service criteria; or (7-1-06)T

f. The child has been suspended or expelled from school and does not meet severity of illness and intensity of service criteria. (7-1-06)T

702. INPATIENT PSYCHIATRIC HOSPITAL SERVICES - COVERAGE AND LIMITATIONS.

01. Emergency Admissions. An emergency for purposes of a waiver of the prior authorization requirement is defined as the sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person. A court-ordered admission or physician's emergency certificate does not, in itself, justify characterizing the admission as an emergency admission. The severity of illness and intensity of services criteria must be met. The hospital medical record of the admission must include documentation to support that the participant's status upon admission meets the definition of an emergency, as defined in Section 702 of this chapter of rules. The information for authorization of services must be FAXED, or otherwise delivered to the Department on the next business day following the emergency admission. Requests for authorization of emergency admissions must include the same information as required for elective admissions. (7-1-06)T

02. Length of Stay. An initial length of stay will be established by the Department. An

initial length of stay will usually be for no longer than five (5) days. For first time admissions where intensity of services criteria is not met the initial length of stay may not exceed forty-eight (48) hours. A hospital may request a continued stay review from the Department when the appropriate care of the participant indicates the need for hospital days in excess of the originally approved number. The continued stay review request may be made no later than the date authorized by the Department. Approval of additional days will be based on the following criteria: (7-1-06)T

a. Documentation sufficient to demonstrate the medical necessity criteria is still met; (7-1-06)T

b. A plan of care that includes documentation sufficient to demonstrate that the child's psychiatric condition continues to require services which can only be provided on an in-patient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist or other physician qualified to treat mental disease; and (7-1-06)T

c. Documentation sufficient to demonstrate the need for continued hospitalization, and that additional days at in-patient level of care will improve the participant's condition. (7-1-06)T

03. Services Limited. Inpatient psychiatric hospital services are limited to ten (10) days per year. (7-1-06)T

703. INPATIENT PSYCHIATRIC HOSPITAL SERVICES - PROCEDURAL REQUIREMENTS.
Admissions must be authorized by the Department. (7-1-06)T

01. Prior Authorization for Elective Admissions. To qualify for reimbursement, prior authorization must be obtained from the Department prior to an elective admission. An elective admission is defined as one that is planned and scheduled in advance, and is not emergency in nature, as “emergency” is defined in Subsection 702.01 of these rules. Requests for prior authorization must include: (7-1-06)T

a. Diagnosis; and (7-1-06)T

b. Summary of present medical findings including symptoms, complaints and complications indicating the need for admission; and (7-1-06)T

c. Medical history; and (7-1-06)T

d. Mental and physical functional capacity; and (7-1-06)T

e. Prognosis; and (7-1-06)T

f. Recommendation by a physician for admission, preferably the primary care physician. If the child is enrolled in the Healthy Connection (HC) program, a HC referral is required. (7-1-06)T

02. Individual Plan of Care. The individual plan of care is a written plan developed for the participant upon admission to an in-patient psychiatric hospital to improve his condition to the extent that acute psychiatric care is no longer necessary. The plan of care must be developed and implemented within seventy-two (72) hours of admission, reviewed at least every three (3) days, and must: (7-1-06)T

a. Be based on a diagnostic evaluation that includes examination of the medical, behavioral, and developmental aspects of the participant's situation and reflects the need (medical necessity criteria) for in-patient care; and (7-1-06)T

b. Be developed by an interdisciplinary team capable of assessing the child's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities, assessing the potential resources of the child's family, setting the treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team must include at a minimum: (7-1-06)T

i. Board-certified psychiatrist (preferably with a specialty in child psychiatry); or (7-1-06)T

ii. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or (7-1-06)T

iii. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease and a licensed clinical professional counselor; and (7-1-06)T

iv. Either a licensed, clinical or masters social worker or a registered nurse with specialized training or one (1) year's experience in treating mentally ill individuals (preferably children); or (7-1-06)T

v. A licensed occupational therapist who has had specialized training or one (1) year of experience in treating mentally ill individuals (preferably children); and (7-1-06)T

vi. The participant and his parents, legal guardians, or others into whose care he will be released after discharge. (7-1-06)T

c. State treatment objectives (related to conditions that necessitated the admission); and (7-1-06)T

d. Prescribe an integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the child), and experiences designed to meet the objectives; and (7-1-06)T

e. Include a discharge and post discharge plan designed to achieve the child's discharge at the earliest possible time and include plans for coordination of community services to ensure continuity of care with the participant's family, school and community upon discharge. (7-1-06)T

704. INPATIENT PSYCHIATRIC HOSPITAL SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Qualifications. Inpatient hospital psychiatric services for individuals under age twenty-one (21) must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the state of Idaho or the state in which they provide services. Facilities currently providing psychiatric hospital services under the authority of Family and Community Services that are certified by the Health Care Financing Administration have until October 1, 1998 to comply with this requirement. To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services to children. General hospitals licensed to provide services in Idaho which are not JCAHO certified may not bill for psychiatric services beyond emergency screening and stabilization. (7-1-06)T

02. Record Keeping. A written report of each evaluation and the plan of care must be entered into the child's record at the time of admission or if the child is already in the facility, immediately upon completion of the evaluation or plan. (7-1-06)T

03. Utilization Review (UR). The facility must have in effect a written utilization review plan that provides for review of each child's need for the services that the hospital furnishes him. The UR plan must meet the requirements under 42 CFR 456.201 through 456.245. (7-1-06)T

705. INPATIENT PSYCHIATRIC HOSPITAL SERVICES - PROVIDER REIMBURSEMENT.

Failure to request a preadmission or continued stay review in a timely manner will result in a retrospective review being conducted by the Department. If the retrospective review determines the admission is medically necessary, the Department will assess a penalty to the hospital as specified in Subsection 705.02 of this rule. The primary care physician will be assessed a penalty for failure to request a preadmission review in a timely manner as specified in Subsection 705.03 of this rule. A physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant is not subject to this penalty. (7-1-06)T

01. Payment. Reimbursement for the participant's admission and length of stay is subject to preadmission, concurrent or retrospective review by the Department. The hospital and the participant's physician are responsible for obtaining the required review. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. (7-1-06)T

a. In reimbursing for inpatient hospital psychiatric services the Department will pay the ~~lessor~~ lesser of customary charges or the reasonable cost of semi-private rates for inpatient hospital care in accordance with the rules set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(7-1-06)T~~(7-1-06)T

b. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric hospital services. (7-1-06)T

c. The participant may be charged for services only when he or she has made an informed decision to incur expenses for services deemed not medically necessary by the Department. (7-1-06)T

02. Hospital Penalty Schedule. Failure to request a preadmission or continued stay review from the Department in a timely manner will result in the hospital being assessed a penalty as follows. The penalty will be assessed after payment for hospital services for a medically necessary hospital admission: (7-1-06)T

a. A request for a preadmission or continued stay review that is one (1) day late will result in a penalty of two hundred sixty dollars ($260). (7-1-06)T

b. A request for a preadmission or continued stay review that is two (2) days late will result in a penalty of five hundred twenty dollars ($520). (7-1-06)T

c. A request for a preadmission or continued stay review that is three (3) days late will result in a penalty of seven hundred eighty dollars ($780). (7-1-06)T

d. A request for a preadmission or continued stay review that is four days (4) late will result in a penalty of one thousand forty dollars ($1,040). (7-1-06)T

e. A request for a preadmission or continued stay review that is five (5) or more days late will result in a penalty of one thousand three hundred dollars ($1,300). (7-1-06)T

03. Physician Penalty Schedule. Failure to request a preadmission review from the Department in a timely manner will result in the primary care physician being assessed a penalty as follows. The penalty will not be assessed against a physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant. The penalty will be assessed after payment for physician services for a medically necessary hospital admission: (7-1-06)T

a. A request for a preadmission review that is one (1) day late will result in a penalty of fifty dollars ($50). (7-1-06)T

b. A request for a preadmission review that is two (2) days late will result in a penalty of one hundred dollars ($100). (7-1-06)T

c. A request for a preadmission review that is three (3) days late will result in a penalty of one hundred fifty dollars ($150). (7-1-06)T

d. A request for a preadmission review that is four (4) days late will result in a penalty of two hundred dollars ($200). (7-1-06)T

e. A request for a preadmission review that is five (5) or more days late will result in a penalty of two hundred fifty dollars ($250). (7-1-06)T

706. INPATIENT PSYCHIATRIC HOSPITAL SERVICES - QUALITY ASSURANCE.

The policy, rules and regulations to be followed must be those cited in 42 CFR 456.480 through 42 CFR 456.482. (7-1-06)T

~~707. -- 709. (RESERVED).~~

7~~1~~0<u>7</u>. MENTAL HEALTH CLINIC SERVICES - DEFINITIONS.

01. Adult. An adult is an individual who is eighteen (18) years of age or older for the purposes of Mental Health Clinic and other outpatient mental health services. (7-1-06)T

02. Mental Health Clinic. A mental health clinic, also referred to as "agency," must be a proprietorship, partnership, corporation, or other entity, in a distinct location, employing at least two (2) staff qualified to deliver clinic services under this rule and operating under the direction of a physician. (7-1-06)T

03. Psychiatric Nurse, Licensed Master's Level. A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (7-1-06)T

04. Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments. (7-1-06)T

<u>05.</u> ***<u>Social History</u>***<u>*. A social history contains a description of the reason(s) the participant is seeking services, a description of his current symptoms, present life circumstances, recent events, his resources, and barriers to mental health treatment. (7-1-06)T*</u>

7~~11~~<u>08</u>. MENTAL HEALTH CLINIC SERVICES - PARTICIPANT ELIGIBILITY.
If an individual who is not eligible for medical assistance receives intake services from any staff not having the required degree(s) as provided in Subsection ~~*714.13*~~ <u>*715.03*</u> of these rules, and later becomes eligible for medical assistance, a new intake assessment and individualized treatment plan will be required which must be developed by a qualified staff person and authorized prior to any reimbursement. ~~*(7-1-06)T*~~(7-1-06)T

<u>709. MENTAL HEALTH CLINIC SERVICES - WRITTEN INDIVIDUALIZED TREATMENT PLAN.</u>
<u>*A written individualized treatment plan is a medically-ordered plan of care. An individualized treatment plan must be developed and implemented for each participant receiving mental health clinic services. Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 715.03 of these rules. (7-1-06)T*</u>

<u>01.</u> ***<u>Individualized Treatment Plan Development</u>***<u>*. The individualized treatment plan must be developed by the following: (7-1-06)T*</u>

a. The clinic staff providing the services; and (7-1-06)T

b. The adult participant, if capable, and the adult participant's legal guardian, or in the case of a minor the minor's parent or legal guardian. The participant or his parent or legal guardian may also choose others to participate in the development of the plan. (7-1-06)T

02. Individualized Treatment Plan Requirements. An individualized treatment plan must include, at a minimum, the following: (7-1-06)T

a. Statement of the overall goals and concrete, measurable treatment objectives to be achieved by the participant, including time frames for completion. The goals and objectives must be individualized and must be directly related to the clinic service needs that are identified in the assessment. (7-1-06)T

b. Documentation of who participated in the development of the individualized treatment plan. (7-1-06)T

i. The authorizing physician must sign and date the plan within thirty (30) calendar days of the initiation of treatment. (7-1-06)T

ii. The adult participant, the adult participant's legal guardian, or in the case of a minor the minor's parent or legal guardian must sign the treatment plan indicating their participation in its development. If these signatures indicating participation in the development of the treatment plan are not obtained, then the agency must document in the participant's record the reason the signatures were not obtained, including the reason for the participant's refusal to sign. A copy of the treatment plan must be given to the adult participant and his legal guardian or to his parent or legal guardian if the participant is a minor. (7-1-06)T

iii. Other individuals who participated in the development of the treatment plan must sign the plan. (7-1-06)T

iv. The author of the treatment plan must sign the plan and include his title and credentials. (7-1-06)T

c. The diagnosis of the participant must be documented by an examination and be made by a licensed physician or other licensed practitioner of the healing arts, licensed psychologist, licensed clinical professional counselor, licensed clinical social worker, or licensed marriage and family therapist within the scope of his practice under state law; and (7-1-06)T

d. A problem list, and the type, frequency, and duration of treatment estimated to achieve all objectives based on the ability of the participant to effectively utilize services. (7-1-06)T

03. Treatment Plan Review. The treatment plan review by the clinic and the participant must occur within one hundred twenty (120) days and every one hundred twenty (120) days thereafter. During the review, the clinic staff providing the services and the participant must review progress made on objectives and identify objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are

determined by the adult participant or his legal guardian, or in the case of a minor his parent or legal guardian and clinic staff providing the services. *(7-1-06)T*

04. ***Physician Review of Treatment Plan****. Each individualized treatment plan must be reviewed and be completely rewritten and signed by a physician at least annually. Changes in the types or amount of services that are determined during treatment plan reviews must be reviewed and signed by a physician. Projected dates for the participant's reevaluation and the rewrite of the individualized treatment plan must be recorded on the treatment plan.* *(7-1-06)T*

05. ***Continuation of Services****. Continuation of services after the first year must be based on documentation of the following:* *(7-1-06)T*

a. *Description of the ways the participant has specifically benefited from clinic services, and why he continues to need additional clinical services; and* *(7-1-06)T*

b. *The participant's progress toward the achievement of therapeutic goals that would eliminate the need for the service to continue.* *(7-1-06)T*

71~~2~~*0*. MENTAL HEALTH CLINIC SERVICES - COVERAGE AND LIMITATIONS. All mental health clinic services must be provided at the clinic unless provided to an eligible homeless individual. (7-1-06)T

01. Clinic Services -- Mental Health Clinics (MHC). Under 42 CFR 440.90, the Department will pay for preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided by a mental health clinic to a participant who is not an inpatient in a hospital or nursing home or correctional facility except as specified under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 229. (7-1-06)T

02. ~~Care and~~ Services *or Supplies* in Mental Health Clinics *That Are* Not Reimbursed. ~~*(7-1-06)T*~~

~~***a.*** *Inpatient Medical Facilities. The Medical Assistance Program will not pay for mental health clinic services rendered to medical assistance participants residing in inpatient medical facilities including nursing homes, hospitals, or public institutions as defined in 42 CFR 435.1009; or* *(7-1-06)T*~~

~~***b.*** *Scope.*~~ Any service or supplies not included as part of the allowable scope of the Medical Assistance Program~~*; or*~~. ~~*(7-1-06)T*~~(7-1-06)T

~~***c.*** *Non-Qualified Persons. Services provided within the mental health clinic framework by persons other than those qualified to deliver services as specified in Subsection 714.07 of these rules.* *(7-1-06)T*~~

03. Evaluation and Diagnostic Services in Mental Health Clinics. (7-1-06)T

a. *Social History. Social History is a reimbursable evaluation and diagnostic service.* *(7-1-06)T*

~~a~~**b.** Psychological Testing. Psychological testing may be provided as a reimbursable service when provided in direct response to a specific evaluation question. ~~(7-1-06)T~~

~~b.~~ The psychological report must contain the reason for the performance of this service. ~~(7-1-06)T~~

~~c.~~ Agency staff may deliver this service if they meet one (1) of the following qualifications: ~~(7-1-06)T~~(7-1-06)T

i. Licensed Psychologist; (7-1-06)T

ii. Psychologist extenders as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners"; or (7-1-06)T

iii. A qualified therapist listed in Subsection ~~714.15~~ 715.03 of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing. ~~(7-1-06)T~~(7-1-06)T

~~04~~**c.** Psychiatric Diagnostic Interview Exam. A psychiatric diagnostic interview exam may be provided as a reimbursable service when delivered by one (1) of the following licensed professionals: (7-1-06)T

~~a~~*i*. Psychiatrist; (7-1-06)T

~~b~~*ii*. Physician; (7-1-06)T

~~c~~*iii*. Practitioner of the healing arts; (7-1-06)T

~~d~~*iv*. Psychologist; (7-1-06)T

~~e~~*v*. Clinical Social Worker; (7-1-06)T

~~f~~*vi*. Clinical Professional Counselor; or (7-1-06)T

~~g~~*vii*. Licensed Marriage and Family Therapist. (7-1-06)T

~~05~~**d.** Evaluations Performed by Occupational Therapists. Evaluations performed by qualified registered occupational therapists, O.T.R., performed in conjunction with the development of an individualized treatment plan are reimbursable. (7-1-06)T

0~~6~~**4.** **Limitations**. A total of twelve (12) hours is the maximum time allowed for a combination of any evaluative or diagnostic services and individualized treatment plan development provided to an eligible participant in a calendar year. (7-1-06)T

0~~7~~**5.** **Treatment Services in Mental Health Clinics**. (7-1-06)T

a. Psychotherapy. Individual and group psychotherapy must be provided in accordance with the goals specified in the individualized treatment plan. (7-1-06)T

b. Family Psychotherapy. Family psychotherapy services must include at least ~~two~~ *the participant and one* (~~2~~*1*) family member~~s~~ and must be delivered in accordance with the goals of treatment as specified in the individualized treatment plan. ~~(7-1-06)T~~(7-1-06)T

c. Emergency Services. Individual emergency psychotherapy services can be provided by qualified clinic staff at any time. (7-1-06)T

i. Emergency services provided to an eligible participant prior to intake and evaluation is a reimbursable service but must be fully documented in the participant's record; and (7-1-06)T

ii. Each emergency service will be counted as a unit of service and part of the allowable limit per participant unless the contact results in hospitalization. Provider agencies may submit claims for the provision of psychotherapy in emergency situations even when contact does not result in the hospitalization of the participant. (7-1-06)T

~~**d**~~***06*.** **Collateral** ~~**Contractor or Consultation**~~ ***Contact***. Collateral contact will be covered by Medicaid if it is conducted face to face by agency staff qualified to deliver clinical services, and if it is included on the individualized treatment plan and is necessary to gather and exchange information with individuals having a primary relationship to the participant. ~~(7-1-06)T~~(7-1-06)T

0~~8~~*7*. **Psychotherapy Limitations**. Psychotherapy services as set forth in Subsections ~~712.07.a.~~ *710.05.a.* through ~~713.07.c.~~ *710.09.b.* of this rule are limited as described under Subsection ~~712.11~~ *710.10* of this rule. ~~(7-1-06)T~~(7-1-06)T

0~~9~~*8*. **Pharmacological Management**. Pharmacological management consultations must be provided by a physician or other practitioner of the healing arts within the scope of practice defined in their license in direct contact with the participant. (7-1-06)T

a. Consultation must be for the purpose of prescribing, monitoring, and/or administering medication as part of the individualized treatment plan; and (7-1-06)T

b. Pharmacological management, if provided, must be part of the individualized treatment plan and frequency and duration of the treatment must be specified. (7-1-06)T

~~1~~0*9*. **Nursing Services**. Nursing services, when physician ordered and supervised, can be part of the participant's individualized treatment plan. (7-1-06)T

a. Licensed and qualified nursing personnel can supervise, monitor, and administer medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code; and (7-1-06)T

b. The frequency and duration of the treatment must be specified on the participant's individualized treatment plan. (7-1-06)T

1~~1~~*0*. **Limits on Mental Health Clinic Services**. Services provided by Mental Health Clinics are limited to twenty-six (26) services per calendar year. This is for any combination of

evaluation, diagnosis and treatment services. This limitation is in addition to any and all other service limitations described in these rules. (7-1-06)T

711. MENTAL HEALTH CLINIC SERVICES - EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID.

***01. Inpatient Medical Facilities**. The Medical Assistance Program will not pay for mental health clinic services rendered to medical assistance participants residing in inpatient medical facilities including nursing homes, hospitals, or public institutions as defined in 42 CFR 435.1009; or (7-1-06)T*

***02. Non-Reimbursable**. Any service not adequately documented in the participant's record by the signature of the therapist providing the therapy or participant contact, the length of the therapy session, and the date of the contact, will not be reimbursed by the Department. (7-1-06)T*

***03. Non-Eligible Staff**. Any treatment or contact provided as a result of an individualized treatment plan that is performed by any staff other than those qualified to deliver services under Subsection 715.03 of these rules is not be eligible for reimbursement by the Department. (7-1-06)T*

***04. Recoupment**. If a record is determined not to meet minimum requirements as set forth herein, any payments made on behalf of the participant are subject to recoupment. (7-1-06)T*

712. MENTAL HEALTH CLINIC SERVICES - CREDENTIALING RESPONSIBILITIES OF THE DEPARTMENT.

The Department is phasing in the Credentialing Program in 2006. During the first three (3) years of development the following will take place: (7-1-06)T

***01. Reimbursement**. A mental health clinic must be designated as credentialed or provisionally credentialed in order to receive Medicaid reimbursement for services. Any agency that fails to maintain credentialed status will have its Medicaid provider agreement terminated. (7-1-06)T*

***02. Application**. All existing providers and new provider applicants must submit an application for credentialing that will be reviewed in order to proceed with the credentialing process and obtain the required credential by the Department. All initial applications will be responded to within thirty (30) days. If the application is incomplete, the applicant must submit the additional information for the application to be considered further. The application will be reviewed up to three (3) times. If the applicant has not provided the required information by the third submittal, then the application will be denied and the application will not be considered again for twelve (12) months. (7-1-06)T*

***03. Temporary Credentialed Status**. In order for existing providers to be able to continue to provide services during these first three (3) years the Department will grant a one-time temporary credential to all existing providers. (7-1-06)T*

04. **New Providers**. Once the Credentialing Program is initiated new provider applicants will be required to submit an application and successfully complete the credentialing process as a condition for Department approval as a Medicaid provider. (7-1-06)T

05. **Elements of Credentialing**. The initial credentialing process consists of the application and an on-site review for compliance with the requirements of these rules. (7-1-06)T

06. **Deemed Status**. Providers accredited by private accreditation agencies, such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or Commission on the Accreditation of Rehabilitation Facilities (CARF), will be exempt from credentialing processes that the Department deems redundant. (7-1-06)T

07. **Expiration and Renewal of Credentialed Status**. Credentials issued under these rules will be issued for a period up to three (3) years. Unless suspended or revoked, the agency's credential will expire on the date designated by the Department. No later than ninety (90) days before expiration, an agency must apply for renewal of credentials. A site review may be conducted by the Department for renewal applications. (7-1-06)T

08. **Provisional Credentialed Status**. If a new or renewal applicant is found deficient in one (1) or more of the requirements for credentialing, but does not have deficiencies that jeopardize the health and safety of the participants or substantially affect the provider's ability to provide services, a provisional credential may be issued. Provisional credentials will be issued for a period not to exceed one hundred eighty (180) days. During that time, the Department will determine whether the deficiencies have been corrected. If so, then the agency will be credentialed. If not, then the credential will be denied or revoked. (7-1-06)T

09. **Denial or Revocation of Credentialed Status**. The Department may deny or revoke credentials when conditions exist that endanger the health, safety, or welfare of any participant or when the agency is not in substantial compliance with these rules. Additional causes for denial of credentials include the following: (7-1-06)T

a. The provider agency or provider agency applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining credentialed status; (7-1-06)T

b. The provider agency or provider agency applicant has been convicted of or is currently under investigation for fraud, gross negligence, abuse, assault, battery or exploitation; (7-1-06)T

c. The provider agency or provider agency applicant has been convicted of a criminal offense within the past five (5) years other than a minor traffic violation or similar minor offense; (7-1-06)T

d. The provider agency or provider agency applicant has been denied or has had revoked any health facility license or certificate; (7-1-06)T

e. A court has ordered that any provider agency owner or provider agency applicant must not operate a health facility, residential care or assisted living facility, or certified family

home; *(7-1-06)T*

f. *Any owners, employees, or contractors of the provider agency or provider agency applicant are listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, or Medicaid exclusion lists;* *(7-1-06)T*

g. *The provider agency or provider agency applicant is directly under the control or influence, whether financial or other, of any person who is described in Subsections 712.09.a. through 712.09.f. of this rule.* *(7-1-06)T*

10. ***Procedure for Appeal of Denial or Revocation of Credentials****. Immediately upon denial or revocation of credentials, the Department will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."* *(7-1-06)T*

~~***713. MENTAL HEALTH CLINIC SERVICES - PROCEDURAL REQUIREMENTS.***~~

~~***01. Medical Psychosocial Histories****. Medical psychosocial intake histories must be contained in all case files.* *(7-1-06)T*~~

~~***02. Individualized Treatment Plan for Mental Health Clinic Services****. A written individualized treatment plan is a medically-ordered plan of care. An individualized treatment plan must be developed and implemented for each participant receiving mental health clinic services. Treatment planning is reimbursable if conducted by a qualified professional identified in Subsection 714.07 of these rules.* *(7-1-06)T*~~

~~***a.*** *Individualized Treatment Plan Development. The individualized treatment plan must be developed by the following:* *(7-1-06)T*~~

~~*i.* *The clinic staff providing the services; and* *(7-1-06)T*~~

~~*ii.* *The adult participant, if capable, and the adult participant's legal guardian, or, in the case of a minor, the minor's parent or legal guardian. The participant or his parent or legal guardian may also choose others to participate in the development of the plan.* *(7-1-06)T*~~

~~***b.*** *Individualized Treatment Plan Requirements. An individualized treatment plan must include the following, at a minimum:* *(7-1-06)T*~~

~~*i.* *Statement of the overall goals and concrete, measurable treatment objectives to be achieved by the participant, including time frames for completion. The goals and objectives must be individualized and must be directly related to the clinic service needs that are identified in the assessment.* *(7-1-06)T*~~

~~*ii.* *Documentation of who participated in the development of the individualized treatment plan.* *(7-1-06)T*~~

~~*(1)* *The authorizing physician must sign and date the plan within (30) thirty calendar*~~

~~*days from the initiation of treatment.* (7-1-06)T~~

~~*(2) The adult participant, the adult participant's legal guardian or, in the case of a minor, the minor's parent or legal guardian, must sign the treatment plan indicating their participation in its development. If these signatures indicating participation in the development of the treatment plan are not obtained, then the agency must document in the participant's record the reason the signatures were not obtained, including the reason for the participant's refusal to sign. A copy of the treatment plan must be given to the adult participant and his legal guardian or to his parent or legal guardian if the participant is a minor.* (7-1-06)T~~

~~*(3) Other individuals who participated in the development of the treatment plan must sign the plan.* (7-1-06)T~~

~~*(4) The author of the treatment plan must sign the plan and include his title and credentials.* (7-1-06)T~~

~~*iii. The diagnosis of the participant must be documented by an examination and be made by a licensed physician or other licensed practitioner of the healing arts, licensed psychologist, licensed clinical professional counselor, or licensed clinical social worker within the scope of his practice under state law; and* (7-1-06)T~~

~~*iv. A problem list, and the type, frequency, and duration of treatment estimated to achieve all objectives based on the ability of the participant to effectively utilize services.* (7-1-06)T~~

~~***c.*** *Treatment Plan Review. The treatment plan review by the clinic and the participant must occur within one-hundred-twenty (120) days and every one-hundred-twenty (120) days thereafter. During the review, the clinic staff providing the services and the participant must review progress made on objectives and identify objectives that may be added, amended, or deleted from the individualized treatment plan. The attendees of the treatment plan review are determined by the adult participant or his legal guardian, or, in the case of a minor, his parent or legal guardian and clinic staff providing the services.* (7-1-06)T~~

~~***d.*** *Physician Review of Treatment Plan. Each individualized treatment plan must be reviewed and be completely rewritten and signed by a physician at least annually. Changes in the types or amount of services that are determined during treatment plan reviews must be reviewed and signed by a physician. Projected dates for the participant's reevaluation and the rewrite of the individualized treatment plan must be recorded on the treatment plan.* (7-1-06)T~~

~~***e.*** *Authorization for Services. Authorization for services after the first year must be based on documentation of the following:* (7-1-06)T~~

~~*i. Description of the ways the participant has specifically benefited from clinic services, and why he continues to need additional clinical services; and* (7-1-06)T~~

~~*ii. The participant's progress toward the achievement of therapeutic goals that would eliminate the need for the service to continue.* (7-1-06)T~~

~~***03. Informed Consent**. The agency must ensure that participants who receive services through the agency have obtained informed consent from the participant or his legal guardian indicating agreement with all of the elements on the individualized treatment plan including choice of the provider agency, designated services, times, dates, frequencies, objectives, goals, and exit criteria. For minors, informed consent must be obtained from the minor's parent or legal guardian. (7-1-06)T~~

~~***04. Documentation**. All intake histories, psychiatric evaluations, psychological testing, or specialty evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the participant's file for documentation purposes. (7-1-06)T~~

~~***05. Data**. All data gathered must be directed towards formulation of a written diagnosis, problem list, and individualized treatment plan which specifies the type, frequency, and anticipated duration of treatment. (7-1-06)T~~

~~***06. Record Keeping Requirements for Mental Health Clinics**. (7-1-06)T~~

~~***a.** Maintenance. Each mental health clinic will be required to maintain records on all services provided to medical assistance participants. (7-1-06)T~~

~~***b.** Record Contents. The records must contain the current individualized treatment plan ordered by a physician and must meet the requirements as set forth in Subsection 713.02 of this rule. (7-1-06)T~~

~~***c.** Requirements. The records must: (7-1-06)T~~

~~*i.* Specify the exact type of treatment provided; and (7-1-06)T~~

~~*ii.* Who the treatment was provided by; and (7-1-06)T~~

~~*iii.* Specify the duration of the treatment and the time of day delivered; and (7-1-06)T~~

~~*iv.* Contain detailed records which outline exactly what occurred during the therapy session or participant contact documented by the person who delivered the service; and(7-1-06)T~~

~~*v.* Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service. (7-1-06)T~~

~~***d.** Non-Reimbursable. Any service not adequately documented in the participant's record by the signature of the therapist providing the therapy or participant contact, the length of the therapy session, and the date of the contact, will not be reimbursed by the Department. (7-1-06)T~~

~~***e.** Non-Eligible Staff. Any treatment or contact provided as a result of an individualized treatment plan that is performed by any staff other than those qualified to deliver services under Subsection 714.07 of these rules is not be eligible for reimbursement by the Department. : (7-1-06)T~~

~~***f.*** *Recoupment. If a record is determined not to meet minimum requirements as set forth herein any payments made on behalf of the participant are subject to recoupment. (7-1-06)T*~~

713. MENTAL HEALTH CLINIC SERVICES - PROVIDER RESPONSIBILITIES.

01. Effectiveness of Services*. Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the individualized treatment plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included on the participant's one hundred twenty (120) day review. (7-1-06)T*

02. Healthy Connections Referral*. Providers must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program. (7-1-06)T*

~~***714. MENTAL HEALTH CLINIC SERVICES -- PROVIDER QUALIFICATIONS AND DUTIES.***~~
~~*Each agency that enters into a provider agreement with the Department for the provision of mental health clinic services must meet the following requirements: (7-1-06)T*~~

~~***01. Mental Health Clinic****. Each location of the agency must meet the requirements under this rule. (7-1-06)T*~~

~~***02. Credentialing****. The Department is phasing in the Credentialing Program in 2006. During the first three (3) years of development the following will take place: (7-1-06)T*~~

~~***a.*** *Reimbursement. A mental health clinic must be designated as credentialed or provisionally credentialed in order to receive Medicaid reimbursement for services. Any agency that fails to maintain credentialed status will have its Medicaid provider agreement terminated. (7-1-06)T*~~

~~***b.*** *Application. All existing providers and new provider applicants must submit an application for credentialing that will be reviewed in order to proceed with the credentialing process and obtain the required credential by the Department. All initial applications will be responded to within thirty (30) days. If the application is complete, the applicant must submit the additional information for the application to be considered further. The application will be reviewed up to three (3) times. If the applicant has not provided the required information by the third submittal then the application will be denied and the application will not be considered again for twelve (12) months. (7-1-06)T*~~

~~***c.*** *Temporary Credentialed Status. In order for existing providers to be able to continue to provide services during these first three (3) years the Department will grant a one-time temporary credential to all existing providers. (7-1-06)T*~~

~~***d.*** *New Providers. Once the Credentialing Program is initiated new provider applicants will be required to submit an application and successfully complete the credentialing process as a condition for Department approval as a Medicaid provider. (7-1-06)T*~~

~~e. Elements of Credentialing. The initial credentialing process consists of the application and an on-site review for compliance with the requirements of these rules. (7-1-06)T~~

~~f. Deemed Status. Providers accredited by private accreditation agencies, such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or Commission on the Accreditation of Rehabilitation Facilities (CARF), will be exempt from credentialing processes that the Department deems redundant. (7-1-06)T~~

~~g. Expiration and Renewal of Credentialed Status. Credentials issued under these rules will be issued for a period up to three (3) years. Unless suspended or revoked, the agency's credential will expire on the date designated by the Department. No later than ninety (90) days before expiration, an agency may apply for renewal of credentials. A site review may be conducted by the Department for renewal applications. (7-1-06)T~~

~~h. Provisional Credentialed Status. If a new or renewal applicant is found deficient in one (1) or more of the requirements for credentialing, but does not have deficiencies that jeopardize the health and safety of the participants or substantially affect the provider's ability to provide services, a provisional credential may be issued. Provisional credentials will be issued for a period not to exceed one hundred and eighty (180) days. During that time, the Department will determine whether the deficiencies have been corrected. If so, then the agency will be credentialed. If not, then the credential will be denied or revoked. (7-1-06)T~~

~~i. Denial, or Revocation of Credentialed Status. The Department may deny or revoke credentials when conditions exist that endanger the health, safety, or welfare of any participant or when the agency is not in substantial compliance with these rules. Additional causes for denial of credentials include the following: (7-1-06)T~~

~~i. The provider agency or provider agency applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining credentialed status; (7-1-06)T~~

~~ii. The provider agency or provider agency applicant has been convicted of, or is currently under investigation for fraud, gross negligence, abuse, assault, battery or exploitation; (7-1-06)T~~

~~iii. The provider agency or provider agency applicant has been convicted of a criminal offense within the past five (5) years, other than a minor traffic violation or similar minor offense; (7-1-06)T~~

~~iv. The provider agency or provider agency applicant has been denied or has had revoked any health facility license, or certificate; (7-1-06)T~~

~~v. A court has ordered that any provider agency owner or provider agency applicant must not operate a health facility, residential care or assisted living facility, or certified family home; (7-1-06)T~~

~~vi. Any owners, employees, or contractors of the provider agency or provider agency applicant are listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual~~

~~*Offender Registry, or Medicaid exclusion lists;* (7-1-06)T~~

~~*vii. The provider agency or provider agency applicant is directly under the control or influence, whether financial or other, of any person who is described in Subsections 714.02.i.i. through 714.02.i.vi. of this rule.* (7-1-06)T~~

~~***j.** Procedure for Appeal of Denial or Revocation of Credentials. Immediately upon denial or revocation of credentials, the Department will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."* (7-1-06)T~~

~~***03. Physician Requirement for Clinic Supervision**. In order to fulfill the requirement that the clinic be under the direction of a physician, the clinic must have a contract with the physician.* (7-1-06)T~~

~~***a.** The contract must specifically require that the physician spend as much time in the clinic as is necessary to assure that participants are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice.* (7-1-06)T~~

~~***b.** The supervising physician of the clinic may also serve as the supervising physician of a participant's care.* (7-1-06)T~~

~~***04. Physician Requirement for Supervision of a Participant's Care**. Each participant's care must be under the supervision of a physician directly affiliated with the clinic. Documentation of the affiliation must be kept in the clinic location. The clinic may have as many physician affiliations as is necessary in order to meet the needs of the volume of participants served in that location. The physician who supervises a participant's care does not have to deliver this service at the clinic nor does the physician have to be present at the clinic when the participant receives services at the clinic. In order to fulfill the requirement for physician supervision of a participant's care, the following conditions must also be met:* (7-1-06)T~~

~~***a.** The clinic and the physician must enter into a formal arrangement in which the physician must assume professional responsibility for the services provided;* (7-1-06)T~~

~~***b.** The physician must see the participant at least once to determine the medical necessity and appropriateness of clinic services;* (7-1-06)T~~

~~***c.** The physician must review and sign the individualized treatment plan as an indicator that the services are prescribed; and* (7-1-06)T~~

~~***d.** The physician must review and sign all updates to the individualized treatment plan that involve changes in the types or amounts of services.* (7-1-06)T~~

~~***05. Assessment**. All treatment in mental health clinics must be based on an individualized assessment of the patient's needs, including a current mental status examination, and provided under the direction of a licensed physician.* (7-1-06)T~~

~~**06. Criminal History Checks**. (7-1-06)T~~

~~**a.** *The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or clinical services have complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks."* (7-1-06)T~~

~~**b.** *Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check.* (7-1-06)T~~

~~**c.** *Once an employee, subcontractor, or agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction.* (7-1-06)T~~

~~**07. Staff Qualifications**. *The mental health clinic must assure that each agency staff person delivering clinical services to eligible medical assistance participants has, at a minimum, one (1) or more of the following qualifications:* (7-1-06)T~~

~~**a.** *Licensed Psychiatrist;* (7-1-06)T~~

~~**b.** *Licensed Physician or licensed practitioner of the healing arts;* (7-1-06)T~~

~~**c.** *Licensed Psychologist;* (7-1-06)T~~

~~**d.** *Psychologist extender, registered with the Bureau of Occupational Licenses;* (7-1-06)T~~

~~**e.** *Licensed Masters Social Worker;* (7-1-06)T~~

~~**f.** *Licensed Clinical Social Worker;* (7-1-06)T~~

~~**g.** *Licensed Social Worker;* (7-1-06)T~~

~~**h.** *Licensed Clinical Professional Counselor;* (7-1-06)T~~

~~**i.** *Licensed Professional Counselor;* (7-1-06)T~~

~~**j.** *Licensed Marriage and Family Therapist;* (7-1-06)T~~

~~**k.** *Certified Psychiatric Nurse, R.N., as described in Subsection 710.03 of these rules;* (7-1-06)T~~

~~**l.** *Licensed Professional Nurse, R.N.; or* (7-1-06)T~~

~~**m.** *Registered Occupational Therapist, O.T.R.* (7-1-06)T~~

~~**08. Support Staff**. *For the purposes of this rule, support staff is any person who does not meet the qualifications of professionals as listed in Subsection 714.07 of this rule. The agency*~~

~~may elect to employ support staff to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant, or providing general, non-professional supervision. Support staff must not deliver or assist in the delivery of services that are reimbursable by Medicaid. (7-1-06)T~~

~~**09. Agency Employees and Subcontractors**. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (7-1-06)T~~

~~**10. Supervision**. The agency must ensure that staff providing clinical services are supervised according to the following guidelines: (7-1-06)T~~

~~**a.** Standards and requirements for supervision set by the Bureau of Occupational Licenses are met; (7-1-06)T~~

~~**b.** Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement; and (7-1-06)T~~

~~**c.** Documentation of supervision must be maintained by the agency and be available for review by the Department. (7-1-06)T~~

~~**11. Continuing Education**. The agency must ensure that all staff complete twenty (20) hours of continuing education annually in the field in which they are licensed. Documentation of the continuing education hours must be maintained by the agency and be available for review by the Department. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (7-1-06)T~~

~~**12. Ethics**. (7-1-06)T~~

~~**a.** The provider must adopt, adhere to and enforce among its staff who are providing Medicaid reimbursable services a Code of Ethics similar to or patterned after one (1) of the following: (7-1-06)T~~

~~i. US Psychiatric Rehabilitation Association Code of Ethics found at http://www.uspra.org/i4a/pages/index.cfm?pageid=3601; (7-1-06)T~~

~~ii. National Association of Social Workers Code of Ethics found at http://www.naswdc.org/pubs/code/default.asp; (7-1-06)T~~

~~iii. American Psychological Association Code of Ethics found at http://www.apa.org/ethics/code.html; (7-1-06)T~~

~~iv. American Counseling Association Code of Ethics found at http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx. (7-1-06)T~~

~~v. Marriage and Family Therapists Code of Ethics found at www.aamft.org/resources/lrmplan/ethics/ethicscode2001.asp. (7-1-06)T~~

~~**b.** *Evidence of the Agency's Code of Ethics, the discipline(s) upon which it is modeled, and each staff member's training on the code must be submitted to the Department upon request.* (7-1-06)T~~

~~**c.** *The Provider must develop a schedule for providing ethics training to its staff.* (7-1-06)T~~

~~**d.** *The ethics training schedule must provide that new employees receive the training during their first year of employment, and that all staff receive ethics training no less than four (4) hours every four (4) years thereafter.* (7-1-06)T~~

~~**13.** **Qualified Therapist**. *The medical psychosocial intake and plan development is reimbursable if conducted by a primary therapist who, at a minimum, has one (1) or more of the following qualifications:* (7-1-06)T~~

~~**a.** *Licensed Psychologist; or* (7-1-06)T~~

~~**b.** *Psychologist extender, registered with the Bureau of Occupational Licenses; or* (7-1-06)T~~

~~**c.** *Licensed Masters Social Worker, or Licensed Clinical Social Worker, or Licensed Social Worker; or* (7-1-06)T~~

~~**d.** *Certified Psychiatric Nurse, R.N.; or* (7-1-06)T~~

~~**e.** *Licensed Clinical Professional Counselor or Licensed Professional Counselor; or* (7-1-06)T~~

~~**f.** *Licensed Physician or Licensed Psychiatrist; or* (7-1-06)T~~

~~**g.** *Licensed Marriage and Family Therapist; or* (7-1-06)T~~

~~**h.** *Licensed Professional Nurse (RN).* (7-1-06)T~~

~~**14.** **Non-Qualified Staff**. *Any delivery of evaluation, diagnostic service, or treatment designed by any person other than an agency staff person designated as qualified under Sections 712 or 714 of these rules, is not eligible for reimbursement under the Medical Assistance Program.* (7-1-06)T~~

~~**15.** **Staff Qualifications for Psychotherapy Services**. *Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 712.07.a. through 712.07.c. of these rules must have, at a minimum, one (1) or more of the following degrees:* (7-1-06)T~~

~~**a.** *Licensed Psychiatrist; or* (7-1-06)T~~

~~**b.** *Licensed Physician; or* (7-1-06)T~~

~~**c.** *Licensed Psychologist; or* (7-1-06)T~~

~~*d.* *Licensed Clinical Social Worker; or* (7-1-06)T~~

~~*e.* *Licensed Clinical Professional Counselor; or* (7-1-06)T~~

~~*f.* *Licensed Marriage and Family Therapist;* (7-1-06)T~~

~~*g.* *Certified Psychiatric Nurse (RN), as described in Subsection 710.03 of these rules;* (7-1-06)T~~

~~*h.* *Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified under Subsections 714.15.a. through 714.15.g. of this rule;* (7-1-06)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* (7-1-06)T~~

~~*j.* *A Psychologist Extender, registered with the Bureau of Occupational Licenses.* (7-1-06)T~~

~~***16. Building Standards For Mental Health Clinics***. (7-1-06)T~~

~~*a.* *Accessibility. Mental health clinic service providers must be responsive to the needs of the service area and persons receiving services and accessible to persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standard.* (7-1-06)T~~

~~*b.* *Environment. Clinics must be designed and equipped to meet the needs of each participant including, but not limited to, factors such as sufficient space, equipment, lighting and noise control.* (7-1-06)T~~

~~*c.* *Capacity. Clinics must provide qualified staff as listed in Subsection 714.07 of this rule to meet a staff to participant ratio that ensures safe, effective and clinically appropriate interventions.* (7-1-06)T~~

~~*d.* *Fire and Safety Standards.* (7-1-06)T~~

~~*i.* *Clinic facilities must meet all local and state codes concerning fire and life safety. The owner/operator must have the facility inspected at least annually by the local fire authority. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and* (7-1-06)T~~

~~*ii.* *The clinic facility must be structurally sound and must be maintained and equipped to assure the safety of participants, employees and the public; and* (7-1-06)T~~

~~*iii.* *In clinic facilities where natural or man-made hazards are present, suitable fences,*~~

~~guards or railings must be provided to protect participants; and (7-1-06)T~~

~~iv. Clinic facilities must be kept free from the accumulation of weeds, trash and rubbish; and (7-1-06)T~~

~~v. Portable heating devices are prohibited except units that have heating elements that are limited to not more than two hundred twelve (212F) degrees Fahrenheit. The use of unvented, fuel-fired heating devices of any kind are prohibited. All portable space heaters must be U.L. approved as well as approved by the local fire or building authority; and (7-1-06)T~~

~~vi. Flammable or combustible materials must not be stored in the clinic facility; and (7-1-06)T~~

~~vii. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (7-1-06)T~~

~~viii. Water temperatures in areas accessed by participants must not exceed one hundred twenty (120) degrees Fahrenheit; and (7-1-06)T~~

~~ix. Portable fire extinguishers must be installed throughout the clinic facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 714.16.d. of this rule; and (7-1-06)T~~

~~x. Electrical installations and equipment must comply with all applicable local or state electrical requirements. In addition, equipment designed to be grounded must be maintained in a grounded condition and extension cords and multiple electrical outlet adapters must not be utilized unless U.L. approved and the numbers, location, and use of them are approved, in writing, by the local fire or building authority. (7-1-06)T~~

~~xi. There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone or where they can be easily accessed; and (7-1-06)T~~

~~xii. Furnishings, decorations or other objects must not obstruct exits or access to exits. (7-1-06)T~~

~~**e.** Emergency Plans and Training Requirements. (7-1-06)T~~

~~i. Evacuation plans must be posted throughout the facility. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of building. (7-1-06)T~~

~~ii. There must be written policies and procedures covering the protection of all persons in the event of fire or other emergencies; and (7-1-06)T~~

~~iii. All employees must participate in fire and safety training upon employment and at least annually thereafter; and (7-1-06)T~~

~~iv. All employees and partial care participants must engage in quarterly fire drills. At least two (2) of these fire drills must include evacuation of the building; and (7-1-06)T~~

~~v. A brief summary of the fire drill and the response of the response of the employees and partial care participants must be written and maintained on file. The summary must indicate the date and time the drill occurred, problems encountered and corrective action taken. (7-1-06)T~~

~~f. Food Preparation and Storage. (7-1-06)T~~

~~i. If foods are prepared in the clinic facility, they must be stored in such a manner as to prevent contamination and be prepared by sanitary methods. (7-1-06)T~~

~~ii. Except during actual preparation time, cold perishable foods must be stored and served under forty-five (45F) degrees Fahrenheit and hot perishable foods must be stored and served over one hundred forty (140F) degrees Fahrenheit. (7-1-06)T~~

~~iii. Refrigerators and freezers used to store participant lunches and other perishable foods used by participants, must be equipped with a reliable, easily-readable thermometer. Refrigerators must be maintained at forty-five (45F) degrees Fahrenheit or below. Freezers must be maintained at zero (0F) to ten (10F) degrees Fahrenheit or below. (7-1-06)T~~

~~iv. When meals are prepared or provided for by the clinic, meals must be nutritional. (7-1-06)T~~

~~g. Housekeeping and Maintenance Services. (7-1-06)T~~

~~i. The interior and exterior of the clinic facility must be maintained in a clean, safe and orderly manner and must be kept in good repair; and (7-1-06)T~~

~~ii. Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; and (7-1-06)T~~

~~iii. All housekeeping equipment must be in good repair and maintained in a clean, safe and sanitary manner; and (7-1-06)T~~

~~iv. The clinic facility must be maintained free from infestations of insects, rodents and other pests; and (7-1-06)T~~

~~v. The clinic facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. (7-1-06)T~~

~~vi. Garbage will be disposed of in a sanitary manner. It must not be allowed to accumulate and must be placed in leak-proof bags. (7-1-06)T~~

~~h. Firearms. No firearms are permitted in the clinic facility. (7-1-06)T~~

~~i. Plumbing. Restroom facilities must be maintained in good working order and available and accessible to participants while at the clinic in accordance with the Americans with~~

~~*Disabilities Act. This includes the presence of running water for operation of the toilet and washing hands.* (7-1-06)T~~

~~***j.*** *Lighting. Lighting levels must be maintained throughout the clinic facility which are appropriate to the service being provided.* (7-1-06)T~~

~~***k.*** *Drinking Water. Where the source is other than a public water system or commercially bottled, water quality must be tested and approved annually by the district health department.* (7-1-06)T~~

714. MENTAL HEALTH CLINIC SERVICES - PROVIDER AGENCY REQUIREMENTS. *Each agency that enters into a provider agreement with the Department for the provision of mental health clinic services must meet the following requirements:* (7-1-06)T

01. Mental Health Clinic*. Each location of the agency must meet the requirements under this rule.* (7-1-06)T

02. Physician Requirement for Clinic Supervision*. In order to fulfill the requirement that the clinic be under the direction of a physician, the clinic must have a contract with the physician.* (7-1-06)T

a. *The contract must specifically require that the physician spend as much time in the clinic as is necessary to assure that participants are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice.* (7-1-06)T

b. *The supervising physician of the clinic may also serve as the supervising physician of a participant's care.* (7-1-06)T

03. Physician Requirement for Supervision of a Participant's Care*. Each participant's care must be under the supervision of a physician directly affiliated with the clinic. Documentation of the affiliation must be kept in the clinic location. The clinic may have as many physician affiliations as is necessary in order to meet the needs of the volume of participants served in that location. The physician who supervises a participant's care does not have to deliver this service at the clinic nor does the physician have to be present at the clinic when the participant receives services at the clinic. In order to fulfill the requirement for physician supervision of a participant's care, the following conditions must also be met:* (7-1-06)T

a. *The clinic and the physician must enter into a formal arrangement in which the physician must assume professional responsibility for the services provided;* (7-1-06)T

b. *The physician must see the participant at least once to determine the medical necessity and appropriateness of clinic services;* (7-1-06)T

c. *The physician must review and sign the individualized treatment plan as an indicator that the services are prescribed; and* (7-1-06)T

d. *The physician must review and sign all updates to the individualized treatment plan that involve changes in the types or amounts of services.* (7-1-06)T

04. Assessment. All treatment in mental health clinics must be based on an individualized assessment of the participant's needs, including a current mental status examination, and provided under the direction of a licensed physician. (7-1-06)T

05. Criminal History Checks. (7-1-06)T

a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or clinical services have complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." (7-1-06)T

b. Once an employee, subcontractor, or agent of the agency has met the requirements specified in Subsection 009.02.a. of these rules, he may begin working for the agency on a provisional basis. (7-1-06)T

c. Once an employee, subcontractor, or agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction. (7-1-06)T

06. Agency Employees and Subcontractors. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (7-1-06)T

07. Supervision. The agency must ensure that staff providing clinical services are supervised according to the following guidelines: (7-1-06)T

a. Standards and requirements for supervision set by the Bureau of Occupational Licenses are met; (7-1-06)T

b. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement; and (7-1-06)T

c. Documentation of supervision must be maintained by the agency and be available for review by the Department. (7-1-06)T

08. Continuing Education. The agency must ensure that all staff complete twenty (20) hours of continuing education annually in the field in which they are licensed. Documentation of the continuing education hours must be maintained by the agency and be available for review by the Department. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (7-1-06)T

09. Ethics. (7-1-06)T

a. The provider must adopt, adhere to and enforce a Code of Ethics on its staff who are providing Medicaid reimbursable services. The Code of Ethics must be similar to or patterned after one (1) of the following: (7-1-06)T

i. US Psychiatric Rehabilitation Association Code of Ethics found at http://

www.uspra.org/i4a/pages/index.cfm?pageid=3601; (7-1-06)T

ii. National Association of Social Workers Code of Ethics found at http://www.naswdc.org/pubs/code/default.asp; (7-1-06)T

iii. American Psychological Association Code of Ethics found at http://www.apa.org/ethics/code.html; (7-1-06)T

iv. American Counseling Association Code of Ethics found at http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx. (7-1-06)T

v. Marriage and Family Therapists Code of Ethics found at www.aamft.org/resources/lrmplan/ethics/ethicscode2001.asp. (7-1-06)T

b. The Provider must develop a schedule for providing ethics training to its staff. (7-1-06)T

c. The ethics training schedule must provide that new employees receive the training during their first year of employment, and that all staff receive ethics training no less than four (4) hours every four (4) years thereafter. (7-1-06)T

d. Evidence of the Agency's Code of Ethics, the discipline(s) upon which it is modeled, and each staff member's training on the Code must be submitted to the Department upon request. (7-1-06)T

10. Building Standards For Mental Health Clinics. (7-1-06)T

a. Accessibility. Mental health clinic service providers must be responsive to the needs of the service area and persons receiving services and accessible to persons with disabilities as defined in Section 504 of the Federal Rehabilitation Act, the Americans with Disabilities Act, and the uniform federal accessibility standard. (7-1-06)T

b. Environment. Clinics must be designed and equipped to meet the needs of each participant including, but not limited to, factors such as sufficient space, equipment, lighting and noise control. (7-1-06)T

c. Capacity. Clinics must provide qualified staff as listed in Subsection 715.01 of this rule to meet a staff to participant ratio that ensures safe, effective and clinically appropriate interventions. (7-1-06)T

d. Fire and Safety Standards. (7-1-06)T

i. Clinic facilities must meet all local and state codes concerning fire and life safety. The owner/operator must have the facility inspected at least annually by the local fire authority. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A copy of the inspection must be made available upon request and must include documentation of any necessary corrective action taken on violations cited; and (7-1-06)T

ii. The clinic facility must be structurally sound and must be maintained and equipped to assure the safety of participants, employees and the public; and (7-1-06)T

iii. In clinic facilities where natural or man-made hazards are present, suitable fences, guards or railings must be provided to protect participants; and (7-1-06)T

iv. Clinic facilities must be kept free from the accumulation of weeds, trash and rubbish; and (7-1-06)T

v. Portable heating devices are prohibited except units that have heating elements that are limited to not more than two hundred twelve (212F) degrees Fahrenheit. The use of unvented, fuel-fired heating devices of any kind are prohibited. All portable space heaters must be U.L. approved as well as approved by the local fire or building authority; and (7-1-06)T

vi. Flammable or combustible materials must not be stored in the clinic facility; and (7-1-06)T

vii. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (7-1-06)T

viii. Water temperatures in areas accessed by participants must not exceed one hundred twenty (120) degrees Fahrenheit; and (7-1-06)T

ix. Portable fire extinguishers must be installed throughout the clinic facility. Numbers, types and location must be directed by the applicable fire authority noted in Subsection 714.10.d. of this rule; and (7-1-06)T

x. Electrical installations and equipment must comply with all applicable local or state electrical requirements. In addition, equipment designed to be grounded must be maintained in a grounded condition and extension cords and multiple electrical outlet adapters must not be utilized unless U.L. approved and the numbers, location, and use of them are approved in writing by the local fire or building authority. (7-1-06)T

xi. There must be a telephone available on the premises for use in the event of an emergency. Emergency telephone numbers must be posted near the telephone or where they can be easily accessed; and (7-1-06)T

xii. Furnishings, decorations or other objects must not obstruct exits or access to exits. (7-1-06)T

***e.** Emergency Plans and Training Requirements. (7-1-06)T*

i. Evacuation plans must be posted throughout the facility. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of building. (7-1-06)T

ii. There must be written policies and procedures covering the protection of all

persons in the event of fire or other emergencies; and *(7-1-06)T*

iii. All employees must participate in fire and safety training upon employment and at least annually thereafter; and *(7-1-06)T*

iv. All employees and partial care participants must engage in quarterly fire drills. At least two (2) of these fire drills must include evacuation of the building; and *(7-1-06)T*

v. A brief summary of the fire drill and the response of the employees and partial care participants must be written and maintained on file. The summary must indicate the date and time the drill occurred, problems encountered and corrective action taken. *(7-1-06)T*

f. *Food Preparation and Storage.* *(7-1-06)T*

i. If foods are prepared in the clinic facility, they must be stored in such a manner as to prevent contamination and be prepared using sanitary methods. *(7-1-06)T*

ii. Except during actual preparation time, cold perishable foods must be stored and served under forty-five (45F) degrees Fahrenheit and hot perishable foods must be stored and served over one hundred forty (140F) degrees Fahrenheit. *(7-1-06)T*

iii. Refrigerators and freezers used to store participant lunches and other perishable foods used by participants, must be equipped with a reliable, easily-readable thermometer. Refrigerators must be maintained at forty-five (45F) degrees Fahrenheit or below. Freezers must be maintained at zero (0F) to ten (10F) degrees Fahrenheit or below. *(7-1-06)T*

iv. When meals are prepared or provided for by the clinic, meals must be nutritional. *(7-1-06)T*

g. *Housekeeping and Maintenance Services.* *(7-1-06)T*

i. The interior and exterior of the clinic facility must be maintained in a clean, safe and orderly manner and must be kept in good repair; and *(7-1-06)T*

ii. Deodorizers cannot be used to cover odors caused by poor housekeeping or unsanitary conditions; and *(7-1-06)T*

iii. All housekeeping equipment must be in good repair and maintained in a clean, safe and sanitary manner; and *(7-1-06)T*

iv. The clinic facility must be maintained free from infestations of insects, rodents and other pests; and *(7-1-06)T*

v. The clinic facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means. *(7-1-06)T*

vi. Garbage will be disposed of in a sanitary manner. It must not be allowed to accumulate and must be placed in leak-proof bags. *(7-1-06)T*

h. *Firearms. No firearms are permitted in the clinic facility.* (7-1-06)T

i. *Plumbing. Restroom facilities must be maintained in good working order and available and accessible to participants while at the clinic in accordance with the Americans with Disabilities Act. This includes the presence of running water for operation of the toilet and washing hands.* (7-1-06)T

j. *Lighting. Lighting levels must be maintained throughout the clinic facility which are appropriate to the service being provided.* (7-1-06)T

k. *Drinking Water. Where the source is other than a public water system or commercially bottled, water quality must be tested and approved annually by the district health department.* (7-1-06)T

715. MENTAL HEALTH CLINIC SERVICES - AGENCY STAFF QUALIFICATIONS.

01. **Staff Qualifications**. *The mental health clinic must assure that each agency staff person delivering clinical services to eligible medical assistance participants has, at a minimum, one (1) or more of the following qualifications:* (7-1-06)T

a. *Licensed Psychiatrist;* (7-1-06)T

b. *Licensed Physician or Licensed Practitioner of the healing arts;* (7-1-06)T

c. *Licensed Psychologist;* (7-1-06)T

d. *Psychologist Extender, registered with the Bureau of Occupational Licenses;* (7-1-06)T

e. *Licensed Masters Social Worker;* (7-1-06)T

f. *Licensed Clinical Social Worker;* (7-1-06)T

g. *Licensed Social Worker;* (7-1-06)T

h. *Licensed Clinical Professional Counselor;* (7-1-06)T

i. *Licensed Professional Counselor;* (7-1-06)T

j. *Licensed Marriage and Family Therapist;* (7-1-06)T

k. *Certified Psychiatric Nurse, R.N., as described in Subsection 707.03 of these rules;* (7-1-06)T

l. *Licensed Professional Nurse, R.N.; or* (7-1-06)T

m. *Registered Occupational Therapist, O.T.R.* (7-1-06)T

02. **Support Staff**. *For the purposes of this rule, support staff is any person who does not meet the qualifications of professionals as listed in Subsection 715.01 of this rule. The agency may elect to employ support staff to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant, or providing general, non-professional supervision. Support staff must not deliver or assist in the delivery of services that are reimbursable by Medicaid.* (7-1-06)T

03. **Qualified Therapist**. *The social history and individualized treatment plan development is reimbursable if conducted by a primary therapist who, at a minimum, has one (1) or more of the following qualifications:* (7-1-06)T

a. *Licensed Psychologist;* (7-1-06)T

b. *Psychologist Extender, registered with the Bureau of Occupational Licenses;* (7-1-06)T

c. *Licensed Masters Social Worker, or Licensed Clinical Social Worker, or Licensed Social Worker;* (7-1-06)T

d. *Certified Psychiatric Nurse, R.N.;* (7-1-06)T

e. *Licensed Clinical Professional Counselor or Licensed Professional Counselor;* (7-1-06)T

f. *Licensed Physician or Licensed Psychiatrist;* (7-1-06)T

g. *Licensed Marriage and Family Therapist; or* (7-1-06)T

h. *Licensed Professional Nurse (RN).* (7-1-06)T

04. **Non-Qualified Staff**. *Any delivery of evaluation, diagnostic service, or treatment designed by any person other than an agency staff person designated as qualified under Sections 710 or 715 of these rules, is not eligible for reimbursement under the Medical Assistance Program.* (7-1-06)T

05. **Staff Qualifications for Psychotherapy Services**. *Licensed, qualified professionals providing psychotherapy services as set forth in Subsections 710.05.a. through 710.05.c. of these rules must have, at a minimum, one (1) or more of the following degrees:* (7-1-06)T

a. *Licensed Psychiatrist;* (7-1-06)T

b. *Licensed Physician;* (7-1-06)T

c. *Licensed Psychologist;* (7-1-06)T

d. *Licensed Clinical Social Worker;* (7-1-06)T

e. Licensed Clinical Professional Counselor; (7-1-06)T

f. Licensed Marriage and Family Therapist; (7-1-06)T

g. Certified Psychiatric Nurse (RN), as described in Subsection 707.03 of these rules; (7-1-06)T

h. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified under Subsections 715.15.a. through 715.15.g. of this rule; (7-1-06)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 (7-1-06)T

j. A Psychologist Extender, registered with the Bureau of Occupational Licenses. (7-1-06)T

716. MENTAL HEALTH CLINIC SERVICES - RECORD REQUIREMENTS FOR PROVIDERS.

*01. **Social Histories**. Social histories must be contained in all participant medical records. (7-1-06)T*

*02. **Informed Consent**. The agency must ensure that participants who receive services through the agency have obtained informed consent from the participant or his legal guardian indicating agreement with all of the elements on the individualized treatment plan including choice of the provider agency, designated services, times, dates, frequencies, objectives, goals, and exit criteria. For minors, informed consent must be obtained from the minor's parent or legal guardian. (7-1-06)T*

*03. **Documentation**. All intake histories, psychiatric evaluations, psychological testing, or specialty evaluations must be in written form, dated, and fully signed to certify when completed and by whom, and retained in the participant's file for documentation purposes. (7-1-06)T*

*04. **Data**. All data gathered must be directed towards formulation of a written diagnosis, problem list, and individualized treatment plan which specifies the type, frequency, and anticipated duration of treatment. (7-1-06)T*

*05. **Mental Health Clinic Record-Keeping Requirements**. (7-1-06)T*

a. Maintenance. Each mental health clinic will be required to maintain records on all services provided to medical assistance participants. (7-1-06)T

b. Record Contents. The records must contain the current individualized treatment plan ordered by a physician and must meet the requirements as set forth in Section 709 of this rule. (7-1-06)T

c. Requirements. The records must: *(7-1-06)T*

i. Specify the exact type of treatment provided; and *(7-1-06)T*

ii. Who the treatment was provided by; and *(7-1-06)T*

iii. Specify the duration of the treatment and the time of day delivered; and *(7-1-06)T*

iv. Contain detailed records which outline exactly what occurred during the therapy session or participant contact documented by the person who delivered the service; and(7-1-06)T

v. Contain the legible, dated signature, with degree credentials listed, of the staff member performing the service. *(7-1-06)T*

71~~5~~7. MENTAL HEALTH CLINIC SERVICES - PROVIDER REIMBURSEMENT.

01. Services. Payment for clinic services will be made directly to the clinic and will be in accordance with rates established by the Department for the specific services. (7-1-06)T

02. Payment in Full. Each provider of clinic services must accept the Department's payment for such services as payment in full and must not bill the medical assistance participant for any portion of any charges incurred for the cost of his care. (7-1-06)T

03. Third Party. All available third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible participant. Proof of billing other third party payers will be required by the Department. (7-1-06)T

04. Injections. Payment for the administration of injections must be in accordance with rates established by the Department. (7-1-06)T

718. MENTAL HEALTH CLINIC SERVICES - QUALITY OF SERVICES.
The Department must monitor the quality and outcomes of mental health clinic services provided to participants, in coordination with the Divisions of Medicaid, Management Services, Family and Community Services (FACS), and Behavioral Health. *(7-1-06)T*

***~~716. --~~*719. (RESERVED).**

SUB AREA K: HOME HEALTH SERVICES
(Sections 720 Through 729)

720. HOME HEALTH SERVICES - DEFINITIONS.
Home health services encompass services ordered by the participant's attending physician as a part of a plan of care, that include nursing services, home health aide, physical therapy, and occupational therapy. (7-1-06)T

721. (RESERVED).

722. HOME HEALTH SERVICES - COVERAGE AND LIMITATIONS.
Home health visits are limited to one hundred (100) visits per calendar year per person. (7-1-06)T

723. HOME HEALTH SERVICES - PROCEDURAL REQUIREMENTS.

01. Plan of Care Review. All plans of care must be reviewed by the participant's physician at least every sixty (60) days; and (7-1-06)T

02. Review for Necessity. The need for medical supplies and equipment ordered by the participant's physician as required in the care of the participant and suitable for use in the home must be reviewed at least once every sixty (60) days. (7-1-06)T

724. HOME HEALTH SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
In order to participate as a Home Health Agency (HHA) provider for Medicaid-eligible persons, the provider must be licensed as required by the state, and be certified to participate in the Medicare Program. Loss of either state license or Medicare Program certification is cause for termination of Medicaid provider status. (7-1-06)T

725. HOME HEALTH SERVICES - PROVIDER REIMBURSEMENT.

01. Mileage Included in Cost. Payment by the Department for home health services will include mileage as part of the cost of the visit. (7-1-06)T

02. Payment Procedures. Payment for home health services will be limited to the services authorized in Sections 720 through 722 of these rules and must not exceed the lesser of reasonable cost as determined by Medicare or the Medicaid percentile cap. (7-1-06)T

a. For visits performed in the first state fiscal year for which this Subsection is in effect, the Medicaid percentile cap will be established at the seventy fifth percentile of the ranked costs per visit as determined by the Department using the data from the most recent finalized Medicare cost reports on hand in the Department on June 1, 1987. Thereafter, the percentile cap will be revised annually, effective at the beginning of each state fiscal year. Revisions will be made using the data from the most recent finalized Medicare cost reports on hand thirty (30) days prior to the effective date. (7-1-06)T

b. When determining reasonable costs of rented medical equipment ordered by a physician and used for the care of the participant, the total rental cost of a Durable Medical Equipment (DME) item must not exceed one-twelfth (1/12) of the total purchase price of the item. A minimum rental rate of fifteen dollars ($15) per month is allowed on all DME items. 7-1-06)T

c. The Department may enter into lease/purchase agreements with providers in order to purchase medical equipment when the rental charges total the purchase price of the equipment. (7-1-06)T

d. The Department will not pay for services at a cost in excess of prevailing Medicare rates. (7-1-06)T

e. If a person is eligible for Medicare, all services ordered by the physician will be purchased by Medicare, except for the deductible and co-insurance amounts which the Department will pay. (7-1-06)T

726. -- 729. (RESERVED).

SUB AREA L: THERAPIES
(Sections 730 Through 739)

730. PHYSICAL THERAPY SERVICES - DEFINITIONS.

01. Modalities. Modalities are any physical agent applied to produce therapeutic changes to biological tissue, including the application of thermal, acoustic, light, mechanical or electrical energy. (7-1-06)T

02. Therapeutic Procedures. Therapeutic procedures are the application of clinical skills, services, or both that attempt to improve function. (7-1-06)T

731. (RESERVED).

732. PHYSICAL THERAPY SERVICES - COVERAGE AND LIMITATIONS.

01. Service Description. The following modalities, therapeutic procedures, tests, and measurements as described in the Physical Medicine and Rehabilitation Subsection and the Neurology and Neuromuscular Procedures Subsection of the Physician's Current Procedural Terminology are covered. (7-1-06)T

a. CPT procedure code range 97032 through 97036 require direct, one to one, patient contact by the therapist. CPT procedure code range 97010 through 97028 may be performed under the supervision of the physical therapist. Any modality which is not contained in these procedure code ranges must be billed using CPT code 97039 for an unlisted modality, and requires authorization by the Department prior to payment. In this case, physician and therapist information documenting the medical necessity of the modality requested for payment must be provided in writing to the Department. (7-1-06)T

b. All therapeutic procedures require the therapist to have direct, one to one, patient contact. CPT procedure code range 97110 through 97602, but excluding CPT procedure code 97124, massage, and 97545 and 97546, work hardening and conditioning, are eligible for Medicaid payment. Any procedure not described by these procedure codes must be billed using CPT procedure code 97139 as an unlisted procedure, and requires authorization by the Department prior to payment. In this case, physician and therapist documentation of the medical necessity of the therapeutic procedure must be provided in writing to the Department. (7-1-06)T

c. The provision of tests or measurements as described by CPT procedure codes 97750 through 97755 may be reimbursed. The physical therapist may be reimbursed for the

technical component of muscle testing, joint range of motion, electromyography or nerve velocity determinations as described in CPT procedure codes 95831 through 95904 when ordered by a physician. (7-1-06)T

d. The equipment used by the physical therapists to provide services is up to the discretion of the therapist and physician. All therapeutic equipment used by the therapist is included in the fee for service payment and no separate charge may be made to either the Medicaid program or participant. (7-1-06)T

02. Service Limited. Each participant is limited to twenty-five (25) visits of outpatient physical therapy during any calendar year. The Department may authorize additional visits if such services are determined to be medically necessary. Visits to outpatient departments of hospitals and services provided by developmental disability agencies, or independent physical therapists providing physical therapy are included in the limit on the total outpatient physical therapy visits. (7-1-06)T

733. PHYSICAL THERAPY SERVICES - PROCEDURAL REQUIREMENTS.
The Department will pay for physical therapy rendered by or under the supervision of a licensed physical therapist if such services are ordered by the attending physician as part of a plan of care. (7-1-06)T

01. Physician Orders. All physical therapy must be ordered by a physician and such orders must include at a minimum, the service to be provided, frequency, and, where applicable, the duration of each therapeutic session. In the event that services are required for extended periods, these services must be reordered as necessary, but at least every thirty (30) days for all participants except those receiving home health agency services and participants with chronic conditions which require on-going physical therapy. Physical therapy provided by home health agencies must be included in the home health plan of care and be reordered not less often than every sixty (60) days. Individuals with chronic medical conditions, as documented by physician, may be reordered up to every six (6) months. Documentation including the physician orders, care plans, progress or other notes documenting each assessment, therapy session and testing or measurement results must be maintained in the files of the therapist. The absence of such documentation is cause for recoupment of Medicaid payment. (7-1-06)T

734. (RESERVED).

735. PHYSICAL THERAPY SERVICES - PROVIDER REIMBURSEMENT.

01. Payment for Physical Therapy Services. The payment for physical therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. (7-1-06)T

02. Payment Procedures. Payment procedures are as follows: (7-1-06)T

a. *Physical therapy rendered by home health agencies must have, at least every sixty (60) days, physician recertification in writing that those services were medically necessary.* ~~*This information*~~ *The physician recertification* must be on the copy of the physician's order ~~*submitted*~~

~~with the claim~~ *and must be kept on file with the provider*. Physical therapy provided by home health agencies will be paid at a rate per visit as described in Section 725 of these rules and subject to the home health visit limitations contained in Section 722 of these rules. ~~(7-1-06)T~~(7-1-06)T

b. Physical therapists identified by Medicare as independent practitioners and enrolled as Medicaid providers will be paid on a fee-for-service basis. The maximum fee paid will be based upon the Department's fee schedule. Only these practitioners can bill the Department directly for their services. (7-1-06)T

c. Physical therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (7-1-06)T

d. Payment for physical therapy services rendered to participants in long-term care facilities or Developmental Disabilities Agencies is included in the facility or agency reimbursement as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-06)T

736. -- 737. (RESERVED).

738. SPEECH AND OCCUPATIONAL THERAPY SERVICES.
Speech ~~and~~ *Therapy services are covered under these rules when provided by outpatient hospitals and school-based services providers.* Occupational Therapy services are covered under these rules when provided by ~~the following providers:~~ outpatient hospitals, home health agencies, and ~~schools providing~~ school-based services *providers*. ~~(7-1-06)T~~(7-1-06)T

739. (RESERVED).

SUB AREA M: SPEECH LANGUAGE AND HEARING SERVICES
(Sections 740 Through 749)

740. (RESERVED).

741. AUDIOLOGY SERVICES - PARTICIPANT ELIGIBILITY.
When specifically ordered by a physician, all participants are eligible for audiometric examination and testing once in each calendar year. (7-1-06)T

742. AUDIOLOGY SERVICES - COVERAGE AND LIMITATIONS.

The Department will pay for audiometric services and supplies in accordance with the following guidelines and limitations: (7-1-06)T

01. Hearing Aids. The Department will cover the purchase of one (1) hearing aid per participant per lifetime with the following requirements and limitations: (7-1-06)T

a. The following information must be documented and kept on file with the provider:

the participant's diagnosis, the results of the basic comprehensive audiometric exam which includes pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedance testing, the brand name and model type needed. However, the Department will allow medical doctors to forego the impedance test based on their documented judgement. (7-1-06)T

b. Covered services included with the purchase of the hearing aid include proper fitting and refitting of the ear mold or aid, or both, during the first year, instructions related to the aid's use, and extended insurance coverage for two (2) years. (7-1-06)T

c. The following services may be covered in addition to the purchase of the hearing aid: batteries purchased on a monthly basis, follow-up testing, necessary repairs resulting from normal use after the second year, and the refitting of the hearing aid or additional ear molds no more often than forty-eight (48) months from the last fitting. (7-1-06)T

d. Lost, misplaced, stolen or destroyed hearing aids are the responsibility of the participant. The Department has no responsibility for the replacement of any hearing aid. In addition, the Department has no responsibility for the repair of hearing aids that have been damaged as a result of neglect, abuse or use of the aid in a manner for which it was not intended. (7-1-06)T

743. AUDIOLOGY SERVICES - PROCEDURAL REQUIREMENTS.

01. Audiology Examinations. Basic audiometric testing by licensed audiologists or licensed physicians will be covered without prior approval. (7-1-06)T

02. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedance testing must be ordered in writing before the testing is done and kept on file by the provider. (7-1-06)T

744. AUDIOLOGY SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
The following are qualified to provide audiology services as Medicaid providers: (7-1-06)T

01. Audiologist, Licensed. A person licensed to conduct hearing assessment and therapy, in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who either possesses a certificate of clinical competence in audiology from the American Speech, Language and Hearing Association (ASHA) or will be eligible for certification within one (1) year of employment. (7-1-06)T

02. Speech-Language Pathologist, Licensed. A person licensed to conduct speech-language assessment and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. (7-1-06)T

745. AUDIOLOGY SERVICES - PROVIDER REIMBURSEMENT.

01. Payment Procedures. The following procedures must be followed when billing

the Department: (7-1-06)T

a. The Department will only pay the hearing aid provider for an eligible Medicaid participant if a properly completed claim is submitted to the Department within the one (1) year billing limitation. (7-1-06)T

b. Payment will be based upon the Department's fee schedule in accordance with Section 230 of these rules). (7-1-06)T

02. Limitations. The following limitations apply to audiometric services and supplies: (7-1-06)T

a. Hearing aid selection is restricted to the most cost-effective type and model which meets the participant's medical needs. (7-1-06)T

b. Follow-up services are included in the purchase of the hearing aid for the first two (2) years including, but not limited to, repair, servicing and refitting of ear molds. (7-1-06)T

c. Providers are required to maintain warranty and insurance information on file on each hearing aid purchased from them by the Department and are responsible for exercising the use of the warranty or insurance during the first year following the purchase of the hearing aid. (7-1-06)T

d. Providers must not bill participants for charges in excess of the fees allowed by the Department for materials and services. (7-1-06)T

746. -- 749. (RESERVED).

SUB AREA N: DURABLE MEDICAL EQUIPMENT AND SUPPLIES
(Sections 750 Through 779)

750. (RESERVED).

751. DURABLE MEDICAL EQUIPMENT AND SUPPLIES - PARTICIPANT ELIGIBILITY.
The participant has a responsibility to reasonably protect and preserve equipment issued to him. Replacement of medical equipment or supplies that are lost, damaged or broken due to participant misuse or abuse are the responsibility of the participant. (7-1-06)T

752. DURABLE MEDICAL EQUIPMENT AND SUPPLIES - COVERAGE AND LIMITATIONS.
The Department will purchase or rent, when medically necessary, reasonable, and cost effective, durable medical equipment (DME) and medical supplies for participants residing in community settings including those provided by qualified home health providers under home health agency plans of care that meet the requirements found in Sections 720 through 724 of these rules. (7-1-06)T

01. Medical Necessity Criteria. Department standards for medical necessity are those national standards set by Centers for Medicare and Medicaid Services (CMS) in the ~~CMS/~~ Medicare DME ~~coverage~~ MAC Jurisdiction D Supplier ~~m~~Manual. Exceptions to Medicare coverage are contained in Section 752 of this chapter of rules. DME/medical supplies will be purchased or rented only if ordered in writing (signed and dated) by a physician as listed in the ~~CMS/~~Medicare DME ~~coverage~~ MAC Jurisdiction D Supplier ~~m~~Manual. Date of delivery is considered the date of service. The following information to support the medical necessity of the item(s) must be included in the physician's order and accompany all requests for prior authorization or be kept on file with the DME provider for items that do not require prior authorization: ~~(7-1-06)T~~(7-1-06)T

a. The participant's medical diagnosis including current information on the medical condition which requires the use of the supplies and/or medical equipment; and (7-1-06)T

b. An estimate of the time period that the medical equipment or supply item will be necessary and frequency of use. As needed (PRN) orders must include the conditions for use and the expected frequency; and (7-1-06)T

c. For medical equipment, a full description of the equipment needed. All modifications or attachments to basic equipment must be supported; and (7-1-06)T

d. For medical supplies, the type and quantity of supplies necessary must be identified; and (7-1-06)T

e. Documentation of the participant's medical necessity for the item, that meets coverage criteria in the CMS/Medicare DME coverage manual. (7-1-06)T

f. Additional information may be requested by the Department for specific equipment and/or supplies such as, but not limited to, wheelchairs, apnea monitors, oximeters, hospital beds or equipment for which CMS/Medicare has established no coverage criteria. (7-1-06)T

g. Items for convenience, comfort or cosmetic reasons are not covered. (7-1-06)T

02. Coverage Conditions - Equipment. Medical equipment is subject to coverage limitations in the CMS/Medicare DME coverage manual. Additional documentation requirements or coverage beyond those in the CMS/Medicare DME coverage manual include: (7-1-06)T

a. Wheelchairs. The Department will provide the least costly wheelchair that is appropriate to meet the participant's medical needs. Wheelchair rental or purchase requires prior authorization by the Department. (7-1-06)T

i. In addition to the physician's information, each request for purchase of a wheelchair must be accompanied by a written evaluation by a physical therapist or an occupational therapist. The evaluation must include documentation of the appropriateness and cost effectiveness of the specific wheelchair and all modifications and/or attachments and its ability to meet the participant's long-term medical needs. For each request for a rental of a

wheelchair, a physical therapist or an occupational therapist evaluation may be required on a case-by-case basis, to be determined by the Department; (7-1-06)T

ii. Additional wheelchairs or seating systems may be considered within the five (5) year limitation with written documentation from the physician and a written evaluation from a physical therapist or an occupational therapist indicating the reason the current wheelchair no longer meets the participant's medical needs and cannot be modified to meet the participant's needs. All documentation required for a wheelchair or seating system purchase is required. (7-1-06)T

b. Semi-electric hospital beds must be prior authorized by the Department and will be approved only when the physician documents that the participant meets the criteria set by the CMS/Medicare DME coverage manual and the participant lives in an independent living situation where there is no one available to provide assistance with a manual bed a major portion of the day. (7-1-06)T

c. Communication devices will be considered for purchase by the Department under the following conditions. (7-1-06)T

i. The need for the device must be based on a comprehensive history and physical. (7-1-06)T

ii. The individual must lack the ability to communicate needs with the primary care physician or caregiver. (7-1-06)T

iii. If the individual knows sign language or is capable of learning sign language a communication device would not be considered medically necessary. (7-1-06)T

iv. The assessment and evaluation for the communication device must include comprehensive information as related to the individual's ability to communicate and review of the most cost effective devices to meet the individuals needs. Documentation must include:(7-1-06)T

(1) Demographic and biographic summary; (7-1-06)T

(2) Inventory of skills and sensory function; (7-1-06)T

(3) Inventory of present and anticipated future communication needs; (7-1-06)T

(4) Summary of device options; (7-1-06)T

(5) Recommendation for device; and (7-1-06)T

(6) Copy of individual treatment plan. (7-1-06)T

v. Repairs to the device must be prior authorized and must not include modifications, technological improvements or upgrades. (7-1-06)T

vi. Reimbursable supplies include rechargeable batteries, overlays, and symbols.

(7-1-06)T

vii. The use or provision of the system by any individual other than the participant for which the system was authorized is prohibited (7-1-06)T

viii. Training and orientation of the communication device may be billed as speech therapy by Medicaid-approved providers such as a Developmental Disability Agency, or a Hospital that employs a speech therapist. (7-1-06)T

d. Maternity abdominal supports will be covered if the participant has: (7-1-06)T

i. Vulvular varicosities; (7-1-06)T

ii. Perineal edema; (7-1-06)T

iii. Lymphedema; (7-1-06)T

iv. External prolapse of the uterus or bladder; (7-1-06)T

v. Hip separation; (7-1-06)T

vi. Pubic symphysis separation; or (7-1-06)T

vii. Severe abdominal or back strain. (7-1-06)T

e. Apnea monitors when there is documented apneic episodes in the last two (2) months. (7-1-06)T

03. Medical Supply Program Requirements. The Department will purchase no more than a one (1) month supply of necessary medical supplies per calendar month for the treatment or amelioration of a medical condition identified by the attending physician. Limitations for supplies follow the CMS/Medicare DME coverage manual. Supplies in excess of those limitations must be prior authorized by the Department. (7-1-06)T

a. Each request for prior authorization must include all information required in Subsection 752.01 of this rule. (7-1-06)T

b. Supplies other than those listed below will require prior authorization: (7-1-06)T

i. Catheter supplies including catheters, drainage tubes, collection bags, and other incidental supplies; (7-1-06)T

ii. Cervical collars; (7-1-06)T

iii. Colostomy and/or urostomy supplies; (7-1-06)T

iv. Cotton tip applicators; (7-1-06)T

v. Disposable supplies necessary to operate Department-approved medical equipment such as suction catheters, syringes, saline solution, etc.; (7-1-06)T

vi. Dressings and bandages to treat wounds, burns, or provide support to a body part; (7-1-06)T

vii. Fluids for irrigation; (7-1-06)T

viii. Incontinence supplies (See Subsection 752.04.b. of this rule for limitations); (7-1-06)T

ix. Injectable supplies including normal saline and Heparin but excluding all other prescription drug items; (7-1-06)T

x. Blood glucose or urine glucose checking/monitoring materials (tablets, tapes, strips, etc.), lancets; and (7-1-06)T

xi. Therapeutic drug level home monitoring kits. (7-1-06)T

xii. Oral, enteral, or parenteral nutritional products, see Subsection 752.04.a. of this rule additional documentation requirements. (7-1-06)T

04. Coverage Conditions - Supplies. Medical supplies are covered when medical necessity criteria per the CMS/Medicare DME coverage manual or the following medical supply items are subject to the following limitations and additional documentation requirements: (7-1-06)T

a. Nutritional products. Nutritional products will be purchased for participants who meet the CMS/Medicare DME coverage manual criteria, when the supplement is given by tube feeding or orally to meet caloric needs of the participant who cannot maintain growth, weight, and strength commensurate with his general condition from traditional foods alone. (7-1-06)T

i. A nutritional plan must be developed and be on file with the provider and must include appropriate nutritional history, the participant's current height, weight, age and medical diagnosis. For participants under the age of twenty-one (21), a growth chart including weight/height percentile must be included; (7-1-06)T

ii. The plan must include goals for either weight maintenance and/or weight gain and must outline steps to be taken to decrease the participant's dependence on continuing use of nutritional supplements; (7-1-06)T

iii. Documentation of evaluation and updating of the nutritional plan and assessment by a physician as needed but at least annually. (7-1-06)T

b. Incontinent supplies. Incontinent supplies are covered for persons over four (4) years of age only and do not require prior authorization unless the participant needs supplies in excess of the following limitations: (7-1-06)T

i. Diapers are restricted in number to two hundred forty (240) per month. If the physician documents that additional diapers are medically necessary, the Department may authorize additional amounts on an individual basis. (7-1-06)T

ii. Disposable underpads are restricted to one hundred fifty (150) per month. (7-1-06)T

iii. Pullups are only allowed when the participant is participating in a formal toilet training program written by an Occupational Therapist, Qualified Mental Retardation Professional (QMRP), or Developmental Specialist. Documentation for toilet training program must be updated on a yearly basis. (7-1-06)T

753. DURABLE MEDICAL EQUIPMENT AND SUPPLIES - PROCEDURAL REQUIREMENTS.

01. Medical Equipment Program Requirements. All claims for durable medical equipment are subject to the following guidelines: (7-1-06)T

a. Unless specified by the Department, durable medical equipment requires prior authorization by the Department. (7-1-06)T

i. Prior authorization means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. Medicaid payment will be denied for the medical item or service or portions thereof which were provided prior to the submission of a valid prior authorization request. The provider may not bill the Medicaid participant for services not reimbursed by Medicaid solely because the authorization was not requested or obtained in a timely manner. An exception may be allowed on a case-by-case basis where, despite diligent efforts on the part of the provider to submit a request, or events beyond the provider's control prevented it. An item or service will be deemed prior approved where the individual to whom the service was provided was not eligible for Medicaid at the time the service was provided, but was subsequently found eligible pursuant to IDAPA 16.03.05, “Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled,” and the medical item or service provided is approved by the Department by the same guidance that applies to other prior authorization requests. (7-1-06)T

ii. A valid prior authorization request is a written, faxed, or electronic request from a provider of Medicaid for services that contains all information and documentation as required by these rules to justify the medical necessity, amount of and duration for the item or service. (7-1-06)T

b. Unless specified by the Department, all equipment must be rented except when it would be more cost effective to purchase it. Rentals are subject to the following guidelines: (7-1-06)T

i. Rental payments, including intermittent payments, are to be automatically applied to the purchase of the equipment. (7-1-06)T

ii. The Department may choose to continue to rent certain equipment without

purchasing it. Such items include apnea monitors, ventilators, and other respiratory equipment. (7-1-06)T

iii. The total monthly rental cost of a DME item must not exceed one-tenth (1/10) of the total purchase price of the item. (7-1-06)T

c. For codes that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping (if that documentation is provided). (7-1-06)T

d. No reimbursement will be made for the cost of repairs (materials or labor) covered under the manufacturer's warranty. The date of purchase and the warranty period must be kept on file by the DME vendor. The following warranty periods are required to be provided on equipment purchased by the Department: (7-1-06)T

i. A power drive wheelchair must have a minimum one (1) year warranty period; (7-1-06)T

ii. An ultra light or high-strength lightweight wheelchair must have a lifetime warranty period on the frame and crossbraces; (7-1-06)T

iii. All other wheelchairs must have a minimum one (1) year warranty period; (7-1-06)T

iv. All electrical components and new or replacement parts must have a minimum six (6) month warranty period; (7-1-06)T

v. All other DME not specified above must have a minimum one (1) year warranty period; (7-1-06)T

vi. If the manufacturer denies the warranty due to user misuse/abuse, that information must be forwarded to the Department at the time of the request for repair or replacement; (7-1-06)T

vii. The monthly rental payment must include a full service warranty. All routine maintenance, repairs, and replacement of rental equipment are the responsibility of the provider. (7-1-06)T

e. Covered equipment must meet the definition of durable medical equipment and be medically necessary as defined in Section 011 of these rules. All equipment must be prior authorized by the Department except for the following: (7-1-06)T

i. Bilirubin lights (require prior authorization after fourteen (14) days); (7-1-06)T

ii. Commode chairs and toilet seat extenders; (7-1-06)T

iii. Crutches and canes; (7-1-06)T

iv. Electric or hydraulic patient lift devices designed to transfer a person to and from bed to wheelchair or bathtub, but excluding lift chairs, devices attached to motor vehicles, and wall mounted chairs which lift persons up and down stairs; (7-1-06)T

v. Grab bars for the bathroom adjacent to the toilet and/or bathtub; (7-1-06)T

vi. Hand-held showers; (7-1-06)T

vii. Head gear (protective); (7-1-06)T

viii. Hearing aids (see Section 742 of these rules for coverage and limitations); (7-1-06)T

ix. Home blood glucose monitoring equipment; (7-1-06)T

x. Non-implantable intravenous infusion pumps, and/or NG/gastric tube feeding pumps, IV poles/stands, intrathecal administration kits; (7-1-06)T

xi. Hand-held nebulizers and manual or electric percussor; (7-1-06)T

xii. Medication organizers; (7-1-06)T

xiii. Oxygen equipment; (7-1-06)T

xiv. Compressors and breathing circuits, humidifiers used with IPPB or oxygen; (7-1-06)T

xv. Sliding boards and bath benches/chairs; (7-1-06)T

xvi. Suction pumps; (7-1-06)T

xvii. Sheep skins, foam or gel pads or alternating pressure pad with pump for the prevention or treatment of decubitus ulcers; (7-1-06)T

xviii. Traction equipment; and (7-1-06)T

xix. Walkers. (7-1-06)T

02. Notice of Decision. A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has twenty-eight (28) days from the date of the denial to request an administrative hearing on the decision. Hearings will be conducted in accordance with IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-06)T

754. (RESERVED).

755. DURABLE MEDICAL EQUIPMENT AND SUPPLIES - PROVIDER REIMBURSEMENT.

01. Items Included in Per Diem Excluded. No payment will be made for any participant's DME or medical supplies that are included in the per diem payment while such an individual is an inpatient in a hospital nursing facility or ICF/MR. (7-1-06)T

02. Least Costly Limitation. When multiple features, models or brands of equipment or supplies are available, coverage will be limited to the least costly version that will reasonably and effectively meet the minimum requirements of the individual's medical needs. (7-1-06)T

03. Billing Procedures. The Department will provide billing instructions to providers of DME/medical supplies. When prior authorization by the Department is required, the authorization number must be included on the claim form. (7-1-06)T

04. Fees and Upper Limits. The Department will reimburse according to Section 230 of these rules. (7-1-06)T

05. Date of Service. Unless specifically authorized by the Department the date of services for durable medical equipment and supplies is the date of delivery of the equipment and/ or supply(s). The date of service cannot be prior to the vendor receiving all medical necessity documentation (7-1-06)T

756. DURABLE MEDICAL EQUIPMENT AND SUPPLIES - QUALITY ASSURANCE. The use or provision of DME/medical supply items to an individual other than the participant for which such items were ordered is prohibited. The provision of DME/medical supply items that is not supported by required medical necessity documentation is prohibited and subject to recoupment. Violators are subject to penalties for program fraud and/or abuse which will be enforced by the Department. The Department has no obligation to repair or replace any piece of durable medical equipment that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse of the equipment. Participants suspected of the same will be reported to the Surveillance and Utilization Review (SUR/S) committee. (7-1-06)T

757. -- 760. (RESERVED).

761. OXYGEN AND RELATED EQUIPMENT - PARTICIPANT ELIGIBILITY. Such services are considered reasonable and necessary only for participants with significant hypoxemia and certain related conditions. (7-1-06)T

762. (RESERVED).

763. OXYGEN AND RELATED EQUIPMENT - PROCEDURAL REQUIREMENTS.

01. Medical Necessity Documentation. Oxygen and related equipment are provided only upon the written order of a physician that includes the medical necessity documentation listed in the Medicare the CMS/Medicare DME coverage manual, with the following exceptions: (7-1-06)T

a. A diagnosis of cluster headaches which has not responded to medications and there is documentation of successful treatment on a trial basis in the emergency room or physician's office. (7-1-06)T

b. Lab studies are not required for participants age zero (0) to six (6) months. (7-1-06)T

02. Prior Authorization. Prior authorization for oxygen is required by the Department for the following: (7-1-06)T

a. Participants age seven (7) months to twenty (20) years of age if there is a physician's order but lab study requirements are not met. (7-1-06)T

b. When the diagnosis is cluster headaches. (7-1-06)T

764. OXYGEN AND RELATED EQUIPMENT - PROVIDER QUALIFICATIONS AND DUTIES.
Providers must be eligible for Medicare program participation prior to the issuance of a Medicaid provider number. (7-1-06)T

765. OXYGEN AND RELATED EQUIPMENT - PROVIDER REIMBURSEMENT.
Medicaid will provide payment for oxygen and oxygen-related equipment based upon the Department's fee schedule in accordance with Section 230 of these rules. (7-1-06)T

766. -- 770. (RESERVED).

771. PROSTHETIC AND ORTHOTIC SERVICES - PARTICIPANT ELIGIBILITY.
The Medical Assistance Program will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body within the limitations established by the Department. (7-1-06)T

772. PROSTHETIC AND ORTHOTIC SERVICES - COVERAGE AND LIMITATIONS.

01. Program Requirements. The following program requirements will be applicable for all prosthetic and orthotic devices or services purchased by the Department: (7-1-06)T

a. A temporary lower limb prosthesis will be purchased when documented by the attending physician that it is in the best interest of the participant's rehabilitation to have a temporary lower limb prosthesis prior to a permanent limb prosthesis. A new permanent limb prosthesis will only be requested after the residual limb size is considered stable; (7-1-06)T

b. A request for a replacement prosthesis or orthotic device must be justified to be the least costly alternative as opposed to repairing or modifying the current prosthesis or orthotic device; (7-1-06)T

c. All prosthetic and orthotic devices that require fitting must be provided by an

individual who is certified or registered by the American Board for Certification in Orthotics and/or Prosthetics; (7-1-06)T

d. All equipment that is purchased must be new at the time of purchase. Modification to existing prosthetic and/or orthotic equipment will be covered by the Department; (7-1-06)T

e. Prosthetic limbs purchased by the Department must be guaranteed to fit properly for three (3) months from the date of service; therefore, any modifications, adjustments, or replacements within the three (3) months are the responsibility of the provider that supplied the item at no additional cost to the Department or the participant; (7-1-06)T

f. Not more than ninety (90) days may elapse between the time the attending physician orders the equipment and the preauthorization request is presented to the Department for consideration; (7-1-06)T

g. A reusable prosthetic or orthotic device purchased by the Department will remain the property of the Department and return of the device to the Department may be required when: (7-1-06)T

i. The participant no longer requires the use of the device; or (7-1-06)T

ii. The participant expires. (7-1-06)T

02. Program Limitations. The following limitations apply to all prosthetic and orthotic services and equipment: (7-1-06)T

a. No replacement will be allowed for prosthetic or orthotic devices within sixty (60) months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb, and ordered by the attending physician; (7-1-06)T

b. Refitting, repairs or additional parts must be limited to once per calendar year for all prosthetics and/or orthotics unless it has been documented that a major medical change has occurred to the limb, and ordered by the attending physician; (7-1-06)T

c. All refitting, repairs or alterations require preauthorization based on medical justification by the participant's attending physician; (7-1-06)T

d. Prosthetic and orthotic devices provided for cosmetic or convenience purposes are not covered by the Department. (7-1-06)T

e. Electronically powered or enhanced prosthetic devices are not covered; (7-1-06)T

f. The Department will only authorize corrective shoes or modification to an existing shoe owned by the participant when they are attached to an orthosis or prosthesis or when specially constructed to provide for a totally or partially missing foot; (7-1-06)T

g. Shoes and accessories such as mismatch shoes, comfort shoes following surgery,

shoes to support an overweight individual, or shoes used as bandage following foot surgery, arch supports, foot pads, metatarsal head appliances or foot supports are not covered; and (7-1-06)T

h. Corsets are not a benefit nor are canvas braces with plastic or metal bones. However, special braces enabling a participant to ambulate will be covered when the attending physician documents that the only other method of treatment for this condition would be application of a cast. (7-1-06)T

773. PROSTHETIC AND ORTHOTIC SERVICES - PROCEDURAL REQUIREMENTS.
Prosthetic and orthotic devices and services will be paid for only if prescribed by a physician. The following information must be included in the physicians order and must be kept on file by the provider: (7-1-06)T

01. Full Description of the Services Requested. A full description of the services requested; (7-1-06)T

02. Number of Months the Equipment Will Be Needed and the Participant's Prognosis. Number of months the equipment will be needed and the participant's prognosis; (7-1-06)T

03. Participant's Medical Diagnosis and Condition. The participant's medical diagnosis and the condition which requires the use of the prosthetic and/or orthotic services, supplies, equipment and/or modifications; and (7-1-06)T

04. Modifications to the Prosthetic or Orthotic Device. All modifications to the prosthetic or orthotic device must be supported by the attending physician's description on the prescription. (7-1-06)T

774. (RESERVED).

775. PROSTHETIC AND ORTHOTIC SERVICES - PROVIDER REIMBURSEMENT.
The Department will reimburse according to Section 230 of these rules. (7-1-06)T

776. -- 779. (RESERVED).

SUB AREA O: VISION SERVICES
(Sections 780 Through 789)

780. (RESERVED).

781. VISION SERVICES - PARTICIPANT ELIGIBILITY.
Replacement of broken, lost, or missing glasses is the responsibility of the participant. (7-1-06)T

782. VISION SERVICES - COVERAGE AND LIMITATIONS.
The Department will pay for vision services and supplies in accordance with the guidelines and

limitations listed below. (7-1-06)T

01. Eye Examinations. The Department will pay participating physicians and optometrists for one (1) eye examination during any twelve (12) month period for each eligible Medicaid participant to determine the need for glasses to correct a refractive error. Each eligible Medicaid participant, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive eyeglasses within Department guidelines. (7-1-06)T

02. Lenses. Lenses, single vision or bifocal, will be purchased by the Department not more often than once every four (4) years except when there is documentation of a major visual change as defined by the Department. (7-1-06)T

a. Polycarbonate lenses will be purchased only when there is clear documented evidence that the thickness of the plastic lenses precludes their use (prescriptions above plus or minus two (2) diopters of correction). Documentation must be kept on file by both the examining and supplying providers. (7-1-06)T

b. Scratch resistant coating is required for all plastic and polycarbonate lenses. (7-1-06)T

c. Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of other extreme medical conditions as defined by the Department as defined in the Medical Vendor Provider Handbook. Documentation must be kept on file by both the examining and supplying providers. (7-1-06)T

d. Contact lenses will be covered only with documentation that an extreme myopic condition requiring a correction equal to or greater than minus four (-4) diopters, cataract surgery, keratoconus, or other extreme conditions as defined by the Department that preclude the use of conventional lenses. Prior authorization is required by the Department. (7-1-06)T

03. Replacement Lenses. Replacement lenses will be purchased prior to the four (4) year limitation only with documentation of a major visual change as defined by the Department in the Idaho Medicaid Provider Handbook. (7-1-06)T

04. Frames. Frames will be purchased according to the following guidelines: (7-1-06)T

a. One (1) set of frames will be purchased by the Department not more often than once every four (4) years for eligible participants; (7-1-06)T

b. Except when it is documented by the physician that there has been a major change in visual acuity that cannot be accommodated in lenses that will fit in the existing frames, new frames also may be authorized. (7-1-06)T

05. Non-Covered Items. A Medicaid Provider may receive payment from a Medicaid participant for vision services that are either not covered by the State Plan, or include special features or characteristics that are desired by the participant but are not medically necessary. Non

covered items include Trifocal lenses, Progressive lenses, photo gray, and tint. (7-1-06)T

783 -- 784. (RESERVED).

785. VISION SERVICES - PROVIDER REIMBURSEMENT.
All eyeglass frames and lenses provided to Medicaid participants and paid for by the Medicaid Program will be purchased from the supplier designated by the Department. (7-1-06)T

786. -- 799. (RESERVED).

SUB AREA P: Dental Services
(Sections 800 Through 819)

800. DENTAL SERVICES - DEFINITIONS.
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. (7-1-06)T

801. DENTAL SERVICES - PARTICIPANT ELIGIBILITY.

01. Children's Services. Covered dental services for children (through the month of their twenty-first birthday) are covered in Sections 800 through 805 of these rules. (7-1-06)T

02. Pregnancy-Related Services. Dental services for women on the Pregnant Women (PW) Program are listed in Subsection 802.14 of these rules. (7-1-06)T

03. Adult Coverage. Covered dental services for Medicaid eligible adults (persons who are past the month of their twenty-first birthday) who are not eligible under PW or Qualified Medicare Beneficiary (QMB) are listed in Subsection 802.15 of these rules. (7-1-06)T

04. Orthodontics. Limited to participants age zero (0) to twenty-one (21) years who meet the eligibility requirements, and the Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant. Participants already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the state Medicaid dental consultant. (7-1-06)T

05. Participants Eligible for Other Programs. Participants who have only Qualified Medicare Beneficiary (QMB) eligibility are not eligible for dental services. (7-1-06)T

802. DENTAL SERVICES - COVERAGE AND LIMITATIONS.

01. Covered Dental Services. Dental services are covered by Medicaid as described in Section 801 of these rules. Idaho uses the procedure codes contained in the Current Dental Terminology (CDT) handbook published by the American Dental Association. (7-1-06)T

02 Non-Covered Services. Non-covered services are procedures not recognized by

the American Dental Association (ADA) or services not listed in these rules. (7-1-06)T

03. Diagnostic Dental Procedures.

TABLE 802.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
a. 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 participant 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.
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 participant, not post-operative visit.
b. 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. Seven (7) to eight (8) films. 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.
c. Test And Laboratory Examination.	
D0460	Pulp vitality tests. Includes multiple teeth and contralateral comparison(s) as indicated. Allowed once per visit per day.

TABLE 802.03 - DENTAL DIAGNOSTIC PROCEDURES	
Dental Code	**Description**
D0470	Diagnostic casts.
d. Diagnostic.	
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing.

(7-1-06)T

04. Dental Preventive Procedures. Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

TABLE 802.04 - DENTAL PREVENTIVE PROCEDURES	
Dental Code	**Description**
a. Dental Prophylaxis.	
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.
b. Fluoride Treatments.	
D1203	Topical application of fluoride - one (1) treatment. Prophylaxis not included. Allowed once every six (6) months for participants 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.
c. Other Preventive Services.	
D1351	Sealant - per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for participants under twenty-one (21) years of age. Limited to once per tooth every three (3) years. Tooth designation required.
d. Space Management Therapy. Space maintainers are allowed to hold space for missing teeth for participants 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.

(7-1-06)T

05. Restorations. (7-1-06)T

a. Posterior Restoration. (7-1-06)T

i. 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). (7-1-06)T

ii. A two (2) surface posterior restoration is one in which the restoration extends to two (2) of the five (5) surface classifications. (7-1-06)T

iii. A three (3) surface posterior restoration is one in which the restoration extends to three (3) of the five (5) surface classification surface classifications. (7-1-06)T

iv. 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. (7-1-06)T

b. Anterior Proximal Restoration. (7-1-06)T

i. 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. (7-1-06)T

ii. 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. (7-1-06)T)

iii. 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. (7-1-06)T

iv. 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. (7-1-06)T

c. Amalgams and Resin Restoration. (7-1-06)T

i. Reimbursement for pit restoration is allowed as a one (1) surface restoration. (7-1-06)T

ii. Adhesives (bonding agents), bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration. (7-1-06)T

iii. Liners and bases are included as part of the restoration. If pins are used, they should be reported separately. (7-1-06)T

d. *Crowns.* *(7-1-06)T*

i. 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. *(7-1-06)T*

ii. Requests for re-doing crowns must be submitted for prior approval and include x-ray and justification. (7-1-06)T

TABLE 802.05 - RESTORATIONS	
Dental Code	**Description**
~~d~~e. **Amalgam Restorations**.	
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.
~~e~~f. **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.
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.
~~f~~g. **Crowns**.	
D2710	Crown resin 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.
D2792	Crown, full cast noble metal. Tooth designation required. Prior authorization required.
~~g~~h. **Other Restorative Services**.	
D2920	Re-cement crown. Tooth designation required.
D2930	Prefabricated stainless steel crown - primary tooth. Tooth designation required.

TABLE 802.05 - RESTORATIONS	
Dental Code	**Description**
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.

(7-1-06)T

06. Endodontics. Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth. (7-1-06)T

TABLE 802.06 - ENDODONTICS	
Dental Code	**Description**
a. Pulp Capping.	
D3110	Pulp cap - direct (excluding final restoration). Tooth designation required.
b. Pulpotomy.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required. Not to be construed as the first stage of root canal therapy.
D3221	Pulpal debridement, primary & permanent teeth. For relief of acute pain not to be construed as the first stage of root canal therapy. Not allowed same day as endodontic therapy. Tooth designation required.
c. 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.
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.

TABLE 802.06 - ENDODONTICS	
Dental Code	**Description**
D3348	Retreatment of previous root canal therapy, molar. Tooth designation required.
d. 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.

(7-1-06)T

07. Periodontics.

TABLE 802.07 - PERIODONTICS	
Dental Code	**Description**
a. Surgical Services.	
D4210	Gingivectomy or gingivoplasty - four (4) or more contiguous teeth in quadrant. Quadrant designation required.
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) teeth in quadrant. Quadrant designation required.
b. 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 participants 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 (12) month period. This procedure is indicated for participants 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.

TABLE 802.07 - PERIODONTICS	
Dental Code	**Description**
c. Other Periodontal Services.	
D4910	Periodontal maintenance procedures. Allowed once in a three (3) month period. This procedure is for participants 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 participant's plaque control efficiency.
D4999	Unspecified periodontal procedure. Narrative required when prior authorizing. Requires prior authorization.

(7-1-06)T

08. Prosthodontics. (7-1-06)T

a. Removable Prosthodontics. (7-1-06)T

i. 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. (7-1-06)T

ii. If full dentures are inserted during a month when the participant is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. (7-1-06)T

iii. Medicaid pays for partial dentures once every five (5) years. Partial dentures are limited to participants age twelve (12) and older. One (1) partial per arch is covered. When a partial is inserted during a month when the participant is not eligible but all other work, including laboratory work, is completed during an eligible period, the claim for the partial is allowed. (7-1-06)T

b. Removable Prosthodontics by Codes.

TABLE 802.08.b. - PROSTHODONTICS	
Dental Code	**Description**
i. 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.
ii. Partial Dentures. This includes six (6) months of care following placement. Limited to twelve (12) years and older.	

TABLE 802.08.b. - PROSTHODONTICS	
Dental Code	**Description**
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.
iii. 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.
iv. 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.
v. 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).
vi. 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).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).

TABLE 802.08.b. - PROSTHODONTICS	
Dental Code	**Description**
D5761	Reline mandibular partial denture (laboratory).
vii. 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.
D5899	Unable to deliver full or partial denture. Prior authorization required. If the participant 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.

(7-1-06)T

09. Maxillo-Facial Prosthetics.

TABLE 802.09 - MAXILLO-FACIAL PROSTHETICS	
Dental Code	Description
D5931	Obturator prosthesis, surgical. Narrative required when prior authorizing. Requires prior authorization.
D5932	Obturator prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5933	Obturator prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5934	Mandibular resection prosthesis with guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5935	Mandibular resection prosthesis without guide flange. Narrative required when prior authorizing. Requires prior authorization.
D5936	Obturator prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.
D5951	Feeding aid. Narrative required when prior authorizing. Requires prior authorization.
D5952	Speech aid prosthesis, pediatric. Narrative required when prior authorizing. Requires prior authorization.
D5953	Speech aid prosthesis, adult. Narrative required when prior authorizing. Requires prior authorization.
D5954	Palatal augmentation prosthesis. Narrative required when prior authorizing. Requires prior authorization.
D5955	Palatal lift prosthesis, definitive. Narrative required when prior authorizing. Requires prior authorization.
D5958	Palatal lift prosthesis, interim. Narrative required when prior authorizing. Requires prior authorization.

TABLE 802.09 - MAXILLO-FACIAL PROSTHETICS	
D5959	Palatal life prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5960	Speech aid prosthesis, modification. Narrative required when prior authorizing. Requires prior authorization.
D5982	Surgical stent. Narrative required when prior authorizing. Requires prior authorization.
D5988	Surgical splint. Narrative required when prior authorizing. Requires prior authorization.
D5999	Unspecified maxillofacial prosthesis. Narrative required when prior authorizing. Requires prior authorization.

(7-1-06)T

10. Fixed Prosthodontics.

TABLE 802.10 - FIXED PROSTHODONTICS	
Dental Code	**Description**
Other Fixed Prosthetic Services.	
D6930	Re-cement fixed partial denture.
D6980	Fixed partial denture repair.
D6999	Unspecified fixed prosthodontic procedure, by report. Narrative required when prior authorizing Requires prior authorization.

(7-1-06)T

11. Oral Surgery.

TABLE 802.11 - ORAL SURGERY	
Dental Code	**Description**
a. Simple Extraction.	
D7111	Extraction, coronal remnants - deciduous tooth. Including soft-tissue retained coronal remnants.
D7140	Extraction, erupted tooth or exposed root, routine removal.
b. 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 802.11 - 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.
c. Other Surgical Procedures.	
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. 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 participants under twenty-one (21) years of age.
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption. Tooth designation required. Limited to participants 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.
d. Alveoloplasty.	
D7320	Alveoloplasty not in conjunction with extractions - per quadrant. Quadrant designation is required.
e. Excision of Bone Tissue.	
D7471	Removal of lateral exostosis. Maxilla or mandible. Arch designation required.
f. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
g. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
h. 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.

(7-1-06)T

12. Orthodontics.

TABLE 802.12 - ORTHODONTICS	
Dental Code	**Description**
a. 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.
b. Comprehensive Orthodontic Treatment. The coordinated diagnosis and treatment leading to the improvement of a participant'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.	
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.
D8090	Comprehensive orthodontic treatment of adult dentition. Justification required. Models, panoramic film, and treatment plan are required when prior authorizing. Requires prior authorization.
c. Minor Treatment to Control Harmful Habits.	
D8210	Removable appliance therapy. Removable indicates participant 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 participant 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.
d. Other Services.	
D8670	Adjustments monthly. When utilizing treatment codes D8050, D8060, D8070, D8080 or D8090 a maximum of twenty-four (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.

TABLE 802.12 - ORTHODONTICS	
Dental Code	**Description**
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.

(7-1-06)T

13. Adjunctive General Services.

TABLE 802.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
a. 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.
b. Anesthesia.	
D9220	Deep sedation/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/general anesthesia - each additional fifteen (15) minutes.
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.
c. 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 participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant'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.
d. 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 participant. To be used when participant's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code D9420.

TABLE 802.13 - ADJUNCTIVE GENERAL SERVICES	
Dental Code	**Description**
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 participant. 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.
e. Miscellaneous Service.	
D9920	Behavior Management. May be reported in addition to treatment provided when the participant 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 participant's record identifying the specific behavior problem and the technique used to manage it. Allowed once per participant 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.
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.

(7-1-06)T

14. Pregnant Women (PW) Codes. The following are the only codes covered for women on the Pregnant Women program.

TABLE 802.14 - PREGNANT WOMEN CODES	
Dental Code	**Description**
a. Clinical Oral Examinations.	
D0140	Limited oral evaluation. An evaluation or re-evaluation limited to a specific oral health problem.
b. Radiographs.	

TABLE 802.14 - PREGNANT WOMEN CODES	
Dental Code	**Description**
D0220	Intraoral - periapical - first film.
D0230	Intraoral - periapical - each additional film.
D0330	Panoramic film.
c. Restorative Services.	
D2940	Sedative filling. Tooth designation required.
d. Pulp Capping.	
D3220	Therapeutic pulpotomy (excluding final restoration). Once per tooth. Tooth designation required.
e. Adjunctive Periodontal Services.	
D4341	Periodontal scaling, root planning, four (4) or more contiguous teeth per quadrant. Allowed once in a twelve-month period. This procedure is indicated for participants 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 participants with periodontal disease and is therapeutic, not prophylactic, in nature. Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis.
f. Oral Surgery. Extractions - includes local anesthesia and routine postoperative care.	
D7111	Extraction, coronal remnants - deciuous tooth. Including soft-tissue retained coronal remnants.
D7140	Extraction, erupted tooth or exposed root, routine removal.
g. 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.
D7250	Surgical removal of residual tooth roots (cutting procedure). Tooth designation required.
h. Surgical Incision.	
D7510	Incision and drainage of abscess - intraoral soft tissue, including periodontal origins.
i. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain - minor procedures.
j. Professional Consultation.	

TABLE 802.14 - PREGNANT WOMEN CODES	
Dental Code	**Description**
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 participant's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant'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.
k. 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 participant.
D9440	Office visit - after regularly scheduled hours.
D9930	Treatment of complication (post-surgical) - unusual circumstances.

(7-1-06)T

15. Dental Codes For Adult Services. The following dental codes are covered for adults after the month of their twenty-first birthday.

TABLE 802.15 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
a. Dental Diagnostic Procedures. The definitions for these codes are in Subsection 802.03 of theses rules.	
i. General Oral Evaluations.	
D0120	Periodic oral evaluation.
D0140	Limited oral evaluation.
D0150	Comprehensive oral evaluation.
ii. 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.

TABLE 802.15 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
b.	**Dental Preventive Procedures**. The definitions for these codes are in Subsection 802.04 of theses rules.
i.	Dental Prophylaxis.
D1110	Prophylaxis - adult.
ii.	Fluoride Treatments.
D1204	Topical application of fluoride - prophylaxis not included - adult.
c.	**Dental Restorative Procedures**. The definitions for these codes are in Subsection 802.05 of theses rules.
i.	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.
ii.	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.
iii.	Other Restorative Services.
D2920	Re-cement crown. Tooth designation required.
D2931	Prefabricated stainless steel crown - permanent tooth.
D2940	Sedative filling.
d.	**Endodontics**. The definitions for these codes are in Subsection 802.06 of theses rules.
D3220	Therapeutic pulpotomy.
D3221	Pulpal debridement, permanent teeth.
e.	**Periodontics**. The definitions for these codes are in Subsection 802.07 of theses rules.
i.	Non-Surgical Periodontal Service.

TABLE 802.15 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
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.
ii. Other Periodontal Services.	
D4910	Periodontal maintenance procedures.
f. **Prosthodontics**. The definitions for these codes are in Subsection 802.08.b. of theses rules.	
i. Complete Dentures.	
D5110	Complete denture - maxillary.
D5120	Complete denture - mandibular.
D5130	Immediate denture - maxillary.
D5140	Immediate denture - mandibular.
ii. Partial Dentures.	
D5211	Maxillary partial denture - resin base.
D5212	Mandibular partial denture - resin base.
iii. Adjustments to Dentures.	
D5410	Adjust complete denture - maxillary.
D5411	Adjust complete denture - mandibular.
D5421	Adjust partial denture - maxillary.
D5422	Adjust partial denture - mandibular.
iv. Repairs to Complete Dentures.	
D5510	Repair broken complete denture base.
D5520	Replace missing or broken teeth - complete denture, each tooth.
v. 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).
vi. Denture Relining.	

TABLE 802.15 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
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).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline maxillary partial denture (laboratory).
D5761	Reline mandibular partial denture (laboratory).
g. **Oral Surgery**. The definitions for these codes are in Subsection 802.11 of theses rules.	
i. Extractions.	
D7111	Extraction, coronal remnants - deciduous tooth.
D7140	Extraction, erupted tooth or exposed root, routine removal.
ii. 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.
iii. Other Surgical Procedures.	
D7286	Biopsy of oral tissue - soft. For surgical removal of specimen only.
iv. Surgical Incision.	
D7510	Incision and drainage of abscess - including periodontal origins.
v. Repair of Traumatic Wounds.	
D7910	Suture of recent small wounds up to five (5) cm.
vi. Other Repair Procedures.	
D7970	Excision of hyperplastic tissue.
D7971	Excision of pericoronal gingiva.
h. **Adjunctive General Services**. The definitions for these codes are in Subsection 802.13 of theses rules.	
i. Unclassified Treatment.	
D9110	Palliative (emergency) treatment of dental pain.
ii. Anesthesia.	

TABLE 802.15 - DENTAL CODES FOR ADULTS	
Dental Code	**Description**
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.
iii. Professional Consultation.	
D9310	Consultation requested by other dentist or physician.
iv. 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.

(7-1-06)T

16. Denturist Procedure Codes.

a. The following codes are valid denturist procedure codes:

TABLE 802.16.a. - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
D5110	Complete denture, upper
D5120	Complete denture, lower
D5130	Immediate denture, upper
D5140	Immediate denture, lower
D5410	Adjust complete denture, upper
D5411	Adjust complete denture, lower
D5421	Adjust partial denture, upper
D5422	Adjust partial denture, lower
D5510	Repair broken complete denture base; arch designation required.
D5520	Replace missing or broken teeth, complete denture (each tooth); six (6) teeth maximum. Tooth designation required.
D5610	Repair resin saddle or base; arch designation required.
D5620	Repair cast framework; arch designation required.
D5630	Repair or replace broken clasp; arch designation required.

TABLE 802.16.a. - DENTURIST PROCEDURE CODES	
Dental Code	**Description**
D5640	Replace broken teeth per tooth; tooth designation required.
D5650	Add tooth to existing partial denture; tooth designation required.
D5660	Add clasp to existing partial denture; not requiring the altering of oral tissue or natural teeth. Tooth designation required.
D5730	Reline complete upper denture (chairside)
D5731	Reline complete lower denture (chairside)
D5740	Reline upper partial denture (chairside)
D5741	Reline lower partial denture (chairside)
D5750	Reline complete upper denture (laboratory)
D5751	Reline complete lower denture (laboratory)
D5760	Reline upper partial denture (laboratory)
D5761	Reline lower partial denture (laboratory)
D5899	Unable to deliver full denture. Prior authorization required. If the participant 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.

(7-1-06)T

b. 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. (7-1-06)T

803. DENTAL SERVICES - PROCEDURAL REQUIREMENTS.

01. 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. (7-1-06)T

02. Denturist Prior Authorization. Prior authorization is not required for the dentist procedures except for dental code D5899 found in Subsection 802.16 of these rules. (7-1-06)T

03. Crowns. (7-1-06)T

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. (7-1-06)T

b. Requests for re-doing crowns must be submitted for prior approval and include x-

ray and justification. (7-1-06)T

804. DENTAL SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
All dental services must be documented in the participant's record to include: procedure, surface, and tooth number (if applicable). This record must be maintained for a period of six (6) years. (7-1-06)T

805. DENTAL SERVICES - PROVIDER REIMBURSEMENT.
Medicaid reimburses dentists and denturists for procedures on a fee-for-service basis. Usual and customary charges 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 participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. ~~*(7-1-06)T*~~(7-1-06)T

806. -- 819. (RESERVED).

SUB AREA Q: ESSENTIAL PROVIDERS
(Sections 820 Through 859)

820. RURAL HEALTH CLINIC (RHC) SERVICES.
A Rural Health Clinic is located in a rural area designated as a physician shortage area, and is neither a rehabilitation agency nor does it primarily provide for the care and treatment of mental diseases. (7-1-06)T

821. -- 822. (RESERVED).

823. RURAL HEALTH CLINIC (RHC) SERVICES - COVERAGE AND LIMITATIONS.
RHC services are defined as follows: (7-1-06)T

01. Physician Services. Physician services; (7-1-06)T

02. Services and Supplies Incident to a Physician Service. Services and supplies incident to a physician service, which cannot be self administered; (7-1-06)T

03. Physician Assistant Services. Physician assistant services; (7-1-06)T

04. Nurse Practitioner or Clinical Nurse Specialist Services. Nurse practitioner or clinical nurse specialist services; (7-1-06)T

05. Clinical Psychologist Services. Clinical psychologist services; (7-1-06)T

06. Clinical Social Worker Services. Clinical social worker services; (7-1-06)T

07. Other Services and Supplies. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist, or clinical social worker as would

otherwise be covered by a physician service; or (7-1-06)T

08. Home Health Agency Shortage Area Services. Part-time or intermittent nursing care, and related medical services to a home bound individual, when an RHC located in an area with a shortage of home health agencies. (7-1-06)T

824. (RESERVED).

825. RURAL HEALTH CLINIC (RHC) SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
A qualified RHC will be recognized a Medicaid provider. (7-1-06)T

826. RURAL HEALTH CLINIC (RHC) SERVICES - REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for Federally Qualified Health Center and Rural Health Clinic services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42USC Section 1396a(bb), Subsections (1) through (4). (7-1-06)T

02. RHC Encounter. An encounter, for RHC payment purposes, is a face-to-face contact for the provision of a medical or mental service between a clinic patient and a provider as specified in 823.01 through 823.06 of these rules. (7-1-06)T

a. Each contact with a separate discipline of health professional (medical or mental) on the same day at the same location is considered a separate encounter. (7-1-06)T

b. Reimbursement for services is limited to two (2) encounters per participant per day. (7-1-06)T

c. As an exception to Subsection 826.02.a. of these rules, a second encounter with the same professional on the same day may be reimbursed; or (7-1-06)T

d. As an exception to Subsection 826.02.b. of these rules, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. (7-1-06)T

e. A core service ordered by a health professional who did not perform the service but was performed by support staff is considered a single encounter. (7-1-06)T

f. Multiple contacts with clinic staff of the same discipline (medical, mental) on the same day related to the same illness or injury are considered a single encounter. (7-1-06)T

827. -- 829. (RESERVED).

830. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES - DEFINITIONS.
Federally qualified health centers are defined in federal law at 42 U.S.C Section 1396d(1)(2),

which incorporates the definition at 42 U.S.C Section 1395x(aa)(1), and includes community health centers, migrant health centers or providers of care for the homeless, outpatient health programs or clinics operated by a tribe or tribal organization under the Indian Self-Determination Act (P.L. 93-638), and clinics that qualify, but are not actually receiving grant funds according to Sections 329, 330, or 340 of the Public Health Service Act (42 U.S.C. Sections 201, et seq.) that may provide ambulatory services to medical assistance participants. (7-1-06)T

831. (RESERVED).

832. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES - COVERAGE AND LIMITATIONS.
FQHC services are defined as follows: (7-1-06)T

01. Physician Services. Physician services; or (7-1-06)T

02. Incidental Services and Supplies to Physician Services. Services and supplies incidental to physician services including drugs and pharmaceuticals which cannot be self-administered; or (7-1-06)T

03. Physician Assistant Services. Physician assistant services; or (7-1-06)T

04. Nurse Practitioner or Clinical Nurse Specialist Services. Nurse practitioner or clinical nurse specialist services; or (7-1-06)T

05. Clinical Psychologist Services. Clinical psychologist services; or (7-1-06)T

06. Clinical Social Worker Services. Clinical social worker services; or (7-1-06)T

07. Licensed Dentist and Dental Hygienist Services. Licensed dentist and dental hygienist services; or (7-1-06)T

08. Incidental Services and Supplies to Non-Physicians. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist, clinical social worker, or dentist or dental hygienist services that would otherwise be covered if furnished by or incident to physician services; or (7-1-06)T

09. FQHC Services. In the case of an FQHC that is located in an area that has a shortage of home health agencies, FQHC services are part-time or intermittent nursing care and related medical services to a home-bound individual; and (7-1-06)T

10. Other Payable Medical Assistance Ambulatory Services. Other payable medical assistance ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide, including pneumococcal or immunization vaccine and its administration. (7-1-06)T

833. (RESERVED).

834. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
A qualified FQHC will be recognized as a Medicaid provider. (7-1-06)T

835. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES - REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for Federally Qualified Health Center and Rural Health Clinic services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42 USC Section 1396a(~~aa~~bb), Subsections (1) through (4). ~~(7-1-06)T~~(7-1-06)T

02. FQHC Encounter. An encounter, for FQHC payment purposes, is a face-to-face contact for the provision of medical, mental, or dental service between a center patient and a provider as specified in Subsections 832.01 through 832.07 of these rules. (7-1-06)T

a. Each contact with a separate discipline of health professional (medical, mental, or dental), on the same day at the same location, is considered a separate encounter. All contacts with all practitioners within a disciplinary category (medical, mental, dental) on the same day is one (1) encounter. (7-1-06)T

b. Reimbursement for services is limited to three (3) encounters per participant per day. (7-1-06)T

c. As an exception to Subsection 835.02.a. of these rules, a second encounter with the same professional on the same day may be reimbursed; or (7-1-06)T

d. As an exception to Subsection 835.02.b. of these rules, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. (7-1-06)T

836. -- 841. (RESERVED).

842. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES - COVERAGE AND LIMITATIONS.
Payment will be available to Indian Health Service (IHS) clinics for any service provided within the conditions of the scope of care and services described in Subsection 835.02 of these rules. (7-1-06)T

843. -- 844. (RESERVED).

845. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES - PROVIDER REIMBURSEMENT.

01. Payment Procedure. Payment for services other than prescribed drugs will be made on a per visit basis at a rate not exceeding the outpatient visit rate established by the Federal Office of Management and Budget as published annually in the Federal Register. (7-1-06)T

02. Payment for Prescribed Drugs. Payment for prescribed drugs will be available as described in Subsection 662.01 of these rules. (7-1-06)T

03. Dispensing Fee for Prescriptions. The allowed dispensing fee used to compute maximum payment for each prescription will be the midpoint dispensing fee of the range of fees in effect at the date of service unless a higher fee is justified by a pharmacy cost of operations report on file with the Department. (7-1-06)T

04. Third Party Liability Not Applicable. The provisions of Section 215 of these rules are not applicable to Indian health service clinics. (7-1-06)T

846. -- 849. (RESERVED).

850. SCHOOL-BASED SERVICES - DEFINITIONS.

***01. Activities of Daily Living (ADL)**. The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (7-1-06)T*

0~~1~~2. Educational Services. Services that are provided in buildings, rooms, or areas designated or used as a school or as educational facilities, which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students, and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations. (7-1-06)T

0~~2~~3. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts*, charter schools,* and the Idaho Infant Toddler program under the Individuals with Disabilities Education Act (IDEA). ~~(7-1-06)T~~(7-1-06)T

851. SCHOOL-BASED SERVICES - PARTICIPANT ELIGIBILITY.
To be eligible for medical assistance reimbursement for covered services, school districts*, charter schools,* and the *Idaho* Infant Toddler Program must ensure the student is: ~~(7-1-06)T~~(7-1-06)T

01. Medicaid Eligible. Eligible for Medicaid and the service for which the school district*, charter school,* or *Idaho* Infant Toddler Program is seeking reimbursement; ~~(7-1-06)T~~(7-1-06)T

02. School Enrollment. Enrolled in an Idaho school district*, charter school,* or the Idaho Infant Toddler Program; ~~(7-1-06)T~~(7-1-06)T

03. Age. Twenty-one (21) years of age or younger and the semester in which his twenty-first birthday falls is not finished; (7-1-06)T

04. Educational Disability. (7-1-06)T

a. Identified as having an educational disability under the Department of Education

standards in IDAPA 08.02.03, "Rules Governing Thoroughness"; or (7-1-06)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 or who meets the eligibility criteria of the Idaho Infant Toddler Program; (7-1-06)T

05. Inpatients in Hospitals or Nursing Homes. Payment for school-related or Infant Toddler-based 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. (7-1-06)T

06. 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. ~~*(7-1-06)T*~~(7-1-06)T

a. Psychosocial Rehabilitation (PSR). To be eligible for PSR, the student must meet the PSR eligibility criteria for children in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 112, 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. (7-1-06)T

b. 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*~~ *standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501*. ~~*(7-1-06)T*~~(7-1-06)T

c. Intensive Behavioral Intervention (IBI). To be eligible for IBI services the student must: (7-1-06)T

i. 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*~~ *standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501*; and ~~*(7-1-06)T*~~(7-1-06)T

ii. 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. (7-1-06)T

iii. Be a child birth through the last day of the month of his twenty-first birthday who has self-injurious, aggressive, or severely maladaptive behavior and severe deficits in the areas of verbal and nonverbal communication, social interaction, or leisure and play skills. (7-1-06)T

852. SCHOOL-BASED SERVICES - COVERAGE AND LIMITATIONS.
The Department will pay school districts, ~~*including*~~ charter schools, and the Idaho Infant Toddler Program, for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. ~~*(7-1-06)T*~~(7-1-06)T

01. Excluded Services. The following services are excluded from Medicaid payments to school-based programs: (7-1-06)T

a. Vocational Services. (7-1-06)T

b. Educational Services. Educational services (other than health related services) or education-based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. (7-1-06)T

c. Recreational Services. (7-1-06)T

02. Evaluation And Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (7-1-06)T

a. Recommended or Referred by a Physician or Other Practitioner of the Healing Arts. Be recommended or referred by a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals; (7-1-06)T

b. Conducted by Qualified Professionals. Be conducted by qualified professionals for the respective discipline as defined in Section 854 of these rules; (7-1-06)T

c. Directed Toward Diagnosis. Be directed toward a diagnosis; and (7-1-06)T

d. Recommend Interventions. Include recommended interventions to address each need. (7-1-06)T

03. Reimbursable Services. School districts, *charter schools,* and *the Idaho* Infant Toddler program~~*s*~~ ~~*may*~~ *can* bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals for the Medicaid services for which the school district, charter school, or *Idaho* Infant Toddler Program is seeking reimbursement. ~~*(7-1-06)T*~~(7-1-06)T

a. Collateral Contact. Consultation or treatment direction about the student to a significant other in the student's life may be face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursed. (7-1-06)T

b. Developmental Therapy and Evaluation. Developmental therapy may be billed,

including evaluation and instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability. (7-1-06)T

c. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be ordered by a physician and prior authorized, based on medical necessity, in order to be billed. Authorized items must be used at school or for the *Idaho* Infant Toddler Program at the location where the service is provided. Equipment that is too large or unsanitary to transport from home to school may be covered if prior authorized. The equipment and supplies must be used for the student's exclusive use and transfer with the student if the student changes schools. Equipment no longer usable by the student, may be donated to the school or *Idaho* Infant Toddler Program by the student. ~~*(7-1-06)T*~~(7-1-06)T

d. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of his practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. (7-1-06)T

e. Occupational Therapy and Evaluation. Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation are not reimbursed. (7-1-06)T

f. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements such as basic personal care and grooming; assistance with bladder or bowel requirements; assistance with eating (including feeding), or other tasks delegated by a licensed professional nurse (RN). (7-1-06)T

g. Physical Therapy and Evaluation. (7-1-06)T

h. Psychological Evaluation. (7-1-06)T

i. Psychotherapy. (7-1-06)T

j. Psychosocial Rehabilitation (PSR) and Evaluation. 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 IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 123 for a description of individual and group PSR services. (7-1-06)T

k. Intensive Behavioral Intervention (IBI). Intensive behavioral interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. Professionals may provide consultation to parents and to other staff

who provide therapy for the child in other disciplines to assure successful integration and transition from IBI to other therapies and environments. (7-1-06)T

l. Speech/Audiological Therapy and Evaluation. (7-1-06)T

m. Social History and Evaluation. (7-1-06)T

n. Transportation Services. School districts*, charter schools,* and *the Idaho* Infant Toddler programs can receive reimbursement for mileage for transporting a student to and from home, school, or location of services when: ~~*(7-1-06)T*~~(7-1-06)T

i. The student requires special transportation assistance such as a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student and ordered by a physician; (7-1-06)T

ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (7-1-06)T

iii. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; (7-1-06)T

iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (7-1-06)T

v. The mileage, as well as the services performed by the attendant, are documented. See Section ~~*576*~~ *854* of these rules for documentation requirements. ~~*(7-1-06)T*~~(7-1-06)T

o. Interpretive Services. Interpretive services needed by a student who does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (7-1-06)T

i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; (7-1-06)T

ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (7-1-06)T

iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (7-1-06)T

853. SCHOOL-BASED SERVICES - PROCEDURAL REQUIREMENTS.

01. 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 (7-1-06)T

02. Referred by a Physician or Other Practitioner of the Healing Arts. 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, *charter school,* or *the Idaho* Infant Toddler Program is receiving reimbursement. ~~*(7-1-06)T*~~(7-1-06)T

854. SCHOOL-BASED SERVICES - PROVIDER QUALIFICATIONS AND DUTIES. In addition to the evaluations and maintenance of the plans, the following documentation must be maintained by the provider and retained for a period of six (6) years: (7-1-06)T

01. Service Detail Reports. A service detail report which includes: (7-1-06)T

a. Name of student; (7-1-06)T

b. Name and title of the person providing the service; (7-1-06)T

c. Date, time, and duration of service; (7-1-06)T

d. Place of service, if provided in a location other than school; and (7-1-06)T

e. Student's response to the service. (7-1-06)T

02. One Hundred Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. (7-1-06)T

03. Documentation of Qualifications of Providers. (7-1-06)T

04. Copies of Required Referrals and Recommendations. Copies of required referrals and recommendations. (7-1-06)T

05. Parental Notification. School districts, *charter schools,* and *the Idaho* Infant Toddler programs must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.06 of this rule. ~~*(7-1-06)T*~~(7-1-06)T

06. Requirements for Cooperation with and Notification of Parents and Agencies. Each school district, *charter school,* or *Idaho* Infant Toddler Program billing for Medicaid services must act in cooperation with students' parents and with community and state agencies and professionals who provide like Medicaid services to the student. ~~*(7-1-06)T*~~(7-1-06)T

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts, *charter schools,* and *the Idaho* Infant Toddler program~~s~~ must ensure that parents are notified of the Medicaid services and equipment for which they will bill Medicaid.

Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration or the service(s). The school district must provide the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and ~~(7-1-06)T~~(7-1-06)T

b. Notification to Primary Care Physician. School districts*, charter schools,* and *the Idaho* Infant Toddler program~~s~~ 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: ~~(7-1-06)T~~(7-1-06)T

i. Results of evaluations within sixty (60) days of completion; (7-1-06)T

ii. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and (7-1-06)T

iii. A copy of progress notes, if requested by the physician, within sixty (60) days of completion. (7-1-06)T

c. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district*, charter school,* or *Idaho* Infant Toddler Program must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. ~~(7-1-06)T~~(7-1-06)T

d. Parental Consent to Release Information. School districts*, charter schools,* and *the Idaho* Infant Toddler program~~s~~: ~~(7-1-06)T~~(7-1-06)T

i. Must obtain consent from the parent to release information regarding education-related services, in accordance with Federal Education Rights and Privacy Act (FERPA) regulations; (7-1-06)T

ii. Must document the parent's denial of consent if the parent refuses to consent to the release of information regarding education-related services, including release of the name of the student's primary care physician. (7-1-06)T

07. Provider Staff Qualifications. Medicaid will only reimburse for services provided by qualified staff. See Subsection 854.08 of this rule for the limitations and requirements for paraprofessional service providers. The following are the minimum qualifications for professional providers of covered services: (7-1-06)T

a. Collateral Contact. Contact and direction must be provided by the professional who provides the treatment to the student. (7-1-06)T

b. Developmental Therapy and Evaluation. Must be provided by or under the direction of a developmental specialist, as set forth in IDAPA 16.04.11, "Developmental Disabilities Agencies." Certified special education teachers are not required to take the Department-approved course indicated in IDAPA 16.04.11 and be certified as a Developmental

Specialist, Child. Only those school personnel who are working under a Letter of Authorization or as a Specialty Consultant must meet the certification requirements in IDAPA 16.04.11. (7-1-06)T

c. Medical Equipment and Supplies. See Subsection 852.03 of these rules. (7-1-06)T

d. Nursing Services. Must be provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) licensed to practice in Idaho. (7-1-06)T

e. Occupational Therapy and Evaluation. Must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. (7-1-06)T

f. Personal Care Services. Must be provided by or under the direction of, a licensed professional nurse (RN) or licensed practical nurse (LPN), licensed by the State of Idaho. When services are provided by a CNA, the CNA must be supervised by an RN. Medically-oriented services having to do with the student's physical or functional requirements, such as basic personal care and grooming, assistance with bladder or bowel requirements, and assistance with eating (including feeding), must be identified on the plan of care and may be delegated to an aide in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-06)T

g. Physical Therapy and Evaluation. Must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. (7-1-06)T

h. Psychological Evaluation. Must be provided by a: (7-1-06)T

i. Licensed psychiatrist; (7-1-06)T

ii. Licensed physician; (7-1-06)T

iii. Licensed psychologist; (7-1-06)T

iv. Psychologist extender registered with the Bureau of Occupational Licenses; or (7-1-06)T

v. Certified school psychologist. (7-1-06)T

i. Psychotherapy. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (7-1-06)T

i. Psychiatrist, M.D.; (7-1-06)T

ii. Physician, M.D.; (7-1-06)T

iii. Licensed psychologist; (7-1-06)T

iv. Licensed clinical social worker; (7-1-06)T

v. Licensed clinical professional counselor; (7-1-06)T

vi. Licensed marriage and family therapist; (7-1-06)T

vii. Certified psychiatric nurse (R.N.), as described in Subsection ~~710.03~~ 707.03 of these rules; ~~(7-1-06)T~~(7-1-06)T

viii. Licensed professional counselor whose provision of psychotherapy is supervised by persons qualified under Subsections 854.07.i.i. through 854.07.i.vii. of this rule; (7-1-06)T

ix. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or (7-1-06)T

x. Psychologist extender registered with the Bureau of Occupational Licenses. (7-1-06)T

j. Psychosocial Rehabilitation. Must be provided by a: (7-1-06)T

i. Licensed physician or psychiatrist; (7-1-06)T

ii. Licensed master's level psychiatric nurse; (7-1-06)T

iii. Licensed psychologist; (7-1-06)T

iv. Licensed clinical professional counselor or professional counselor; (7-1-06)T

v. Licensed marriage and family therapist; (7-1-06)T

vi. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (7-1-06)T

vii. Psychologist extender registered with the Bureau of Occupational Licenses; (7-1-06)T

viii. Clinician; (7-1-06)T

ix. Licensed pastoral counselor; (7-1-06)T

x. Licensed professional nurse (RN); (7-1-06)T

xi. Psychosocial rehabilitation specialist as defined in Section 456 in these rules; (7-1-06)T

xii. Licensed occupational therapist; (7-1-06)T

xiii. Certified school psychologist; or (7-1-06)T

xiv. Certified school social worker. (7-1-06)T

k. Intensive Behavioral Intervention. Must be provided by or under the direction of a qualified professional who meets the requirements set forth in IDAPA 16.04.11 "Developmental Disabilities Agencies." (7-1-06)T

l. Speech/Audiological Therapy and Evaluation. Must be provided by or under the direction of a speech pathologist or audiologist who possesses a certificate of clinical competence from the American Speech, Language and Hearing Association (ASHA); or who will be eligible for certification within one (1) year of employment. Personnel records must reflect the expected date of certification. (7-1-06)T

m. Social History and Evaluation. Must be provided by a licensed professional nurse (RN), psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. (7-1-06)T

n. Transportation. Must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (7-1-06)T

08. Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by the school/Infant Toddler program to provide developmental therapy; occupational therapy; physical therapy; and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be within the scope of practice of an aide or therapy technician as defined by the scope of practice of the therapy professional. The portions of the treatment plan which can be delegated to the paraprofessional must be identified in the IEP or IFSP. (7-1-06)T

a. Competency of Paraprofessional. The professional must have assessed the competence of the paraprofessional or aide to perform assigned tasks. (7-1-06)T

b. Monthly Orientation. The paraprofessional, on a monthly basis, must be given orientation and training on the program and procedures to be followed. (7-1-06)T

c. Reevaluation. The professional must reevaluate the student and adjust the treatment plan as their individual practice dictates. (7-1-06)T

d. Changes in Condition. Any changes in the student's condition not consistent with planned progress or treatment goals necessitates a documented reevaluation by the professional before further treatment is carried out. (7-1-06)T

e. Review of Independent Paraprofessional. If the paraprofessional works independently there must be a review conducted by the appropriate professional at least once per month. This review will include the dated initials of the professional conducting the review. (7-1-06)T

f. Utilizing Paraprofessional to Assist in Provision of Physical Therapy. In addition to the above, if a paraprofessional is utilized to assist in the provision of actual physical therapy

they may do so only when the following conditions are met: (7-1-06)T

i. Student reevaluation must be performed and documented by the supervising PT every five (5) visits or once a week if treatment is performed more than once per day. (7-1-06)T

ii. The number of PTAs utilized in any practice or site, must not exceed twice in number the full time equivalent licensed PTs. (7-1-06)T

855. SCHOOL-BASED SERVICES - PROVIDER REIMBURSEMENT.
Payment for health-related services provided by school districts*, charter schools,* and *the Idaho* Infant Toddler program~~s~~ must be in accordance with rates established by the Department. ~~(7-1-06)T~~(7-1-06)T

01. Payment in Full. Providers of services must accept as payment in full the school district*, charter school,* or *Idaho* Infant Toddler Program payment for such services and must not bill Medicaid or Medicaid participants for any portion of any charges. ~~(7-1-06)T~~(7-1-06)T

02. Third Party. For requirements regarding third party billing, see Section 215 of these rules. (7-1-06)T

03. Contracted Providers. When *an employee of* a school *district, charter school,* or ~~the~~ *Idaho* Infant Toddler program *does not deliver the services identified on the plan, the school district, charter school, or Idaho Infant Toddler Program must* contract~~s~~ with a service provider to deliver *the* services ~~identified on the plan, the school or the Infant Toddler program must~~ *and* bill Medicaid for the contracted services. The contracted service provider must not bill Medicaid or the Medicaid participant. ~~(7-1-06)T~~(7-1-06)T

04. Recoupment of Federal Share. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (7-1-06)T

05. Matching Funds. Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. School districts *and charter schools* must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: ~~(7-1-06)T~~(7-1-06)T

a. Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. (7-1-06)T

b. School districts *and charter schools* will send the Department the matching funds, either by check or *automated clearing house (*ACH*)* electronic funds transfers. ~~(7-1-06)T~~(7-1-06)T

c. The Department will hold matching funds in an interest bearing trust account. The average daily balance during a month must exceed one hundred dollars ($100) in order to receive interest for that month. (7-1-06)T

d. The payments to the districts will include both the federal and non-federal share (matching funds). (7-1-06)T

e. Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. (7-1-06)T

f. If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle. (7-1-06)T

g. The Department will provide the school districts a monthly statement which will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. (7-1-06)T

h. The school districts will estimate the amount of their next billing and the amount of matching funds needed to pay the Department. (7-1-06)T

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. (7-1-06)T

856. SCHOOL-BASED SERVICES - QUALITY ASSURANCE.
The provider will grant the Department immediate access to all information required to review compliance with these rules. (7-1-06)T

857. -- 859. (RESERVED).

SUB AREA R: MEDICAL TRANSPORTATION SERVICES
(Sections 860 Through 879)

860. (RESERVED).

861. EMERGENCY TRANSPORTATION SERVICES - PARTICIPANT ELIGIBILITY.
Ambulance services are medically necessary when an emergency condition exists. For purposes of reimbursement, an emergency condition exists when a participant manifests acute symptoms and/or signs which, by reasonable medical judgement of the Department, represent a condition of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the participant. If such condition exists, and treatment is required at the participant's location, or transport of the participant for treatment in another location by ambulance is the only appropriate mode of travel, the Department will review such claims and consider authorization for emergency ambulance services. (7-1-06)T

862. EMERGENCY TRANSPORTATION SERVICES - COVERAGE AND LIMITATIONS.

01. Prior Authorization. Medically necessary ambulance services are reimbursable in emergency situations or when prior authorization has been obtained from the Department. (7-1-06)T

02. Local Transport Only. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the participant was transported, payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities and the service is authorized by the Department. (7-1-06)T

03. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: (7-1-06)T

a. The point of pickup is inaccessible by land vehicle; or (7-1-06)T

b. Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential; and (7-1-06)T

c. Air ambulance service will be covered where the participant's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. (7-1-06)T

863. EMERGENCY TRANSPORTATION SERVICES - PROCEDURAL REQUIREMENTS.

01. Services Subject to Review. Ambulance services are subject to review by the Department prior to the service being rendered, and on a retrospective basis (7-1-06)T.

02. Non-Emergency Transport Prior Authorization Required. If an emergency does not exist, prior written authorization to transport by ambulance must be secured from the Department. (7-1-06)T

03. Air Ambulance. Air ambulance services must be approved in advance by the Department, except in emergency situations. Emergency air ambulance services will be authorized by the Department on a retrospective basis. (7-1-06)T

864. EMERGENCY TRANSPORTATION SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

01. Medically Necessary. For purposes of reimbursement, in non-emergency situations, the provider must provide justification to the Department that travel by ambulance is medically necessary due to the medical condition of the participant, and that any other mode of travel would, by reasonable medical judgement of the Department, result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the participant. (7-1-06)T

02. Licensure Required. All Emergency Medical Services (EMS) Providers that

provide services to Medicaid participants in Idaho must hold a current license issued by the Emergency Medical Services Bureau of the Department, and must be governed by IDAPA 16.02.03, "Rules Governing Emergency Medical Services." Ambulances based outside the state of Idaho must hold a current license issued by their states' EMS licensing authority when the transport is initiated outside the state of Idaho. Payment will not be made to ambulances that do not hold a current license. (7-1-06)T

03. Usual Charges. Ambulance services providers cannot charge Medicaid participants more than is charged to the general public for the same service. (7-1-06)T

04. Air Ambulance. The operator of the air service must bill the air ambulance service rather than the hospital or other facility receiving the participant. (7-1-06)T

865. EMERGENCY TRANSPORTATION SERVICES - PROVIDER REIMBURSEMENT.

01. Scope of Coverage and General Requirements for Ambulance Services. Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. If such review identifies that an ambulance service is not covered, then no Medicaid payment will be made for the ambulance service. Reimbursement for ambulance services originally denied by the Department will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." Payment for ambulance services is subject to the following limitations: (7-1-06)T

02. Ambulance Reimbursement. (7-1-06)T

a. The base rate for ambulance services includes customary patient care equipment and items such as stretchers, clean linens, reusable devices and equipment. The base rate also includes nonreusable items, and disposable supplies such as oxygen, triangular bandages and dressings that may be required for the care of the participant during transport. In addition to the base rate, the Department will reimburse mileage. (7-1-06)T

b. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department. (7-1-06)T

c. If a physician is in attendance during transport, he is responsible for the billing of his services. (7-1-06)T

d. Reimbursement for waiting time will not be considered unless documentation submitted to the Department identifies the length of the waiting time and establishes its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips . (7-1-06)T

e. Ambulance units are licensed by the EMS Bureau of the Department, or other states' EMS licensing authority according to the level of training and expertise its personnel maintain. At least this level of personnel is required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a base rate according to the

following: (7-1-06)T

i. The level of personnel required to be in the patient compartment of the ambulance; (7-1-06)T

ii. The level of ambulance license the unit has been issued; and (7-1-06)T

iii. The level of life support authorized by the Department. (7-1-06)T

f. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Basic Life Support (BLS) rate. Units with Advanced Emergency Medical Technician-Ambulance (AEMT-A) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level I (ALSI) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level II (ALSII) rate. When a participant's condition requires hospital-to-hospital transport with ongoing care that must be furnished by one (1) or more health care professionals in an appropriate specialty area, including emergency or critical care nursing, emergency medicine, or a paramedic with additional training, Specialty Care Transport (SCT) may be authorized by the Department. (7-1-06)T

g. If multiple licensed EMS providers are involved in the transport of a participant, only the ambulance provider which actually transports the participant will be reimbursed for the services. In situations where personnel and equipment from a licensed ALSII provider boards an ALSI or BLS ambulance, the transporting ambulance may bill for ALSII services as authorized by the Department. In situations where personnel and equipment from a licensed ALSI provider boards an ALSII or BLS ambulance, the transporting ambulance may bill for ALSI services as authorized by the Department. In situations where medical personnel and equipment from a medical facility are present during the transport of the participant, the transporting ambulance may bill at the ALSI or ALSII level of service. The transporting provider must arrange to pay the other provider for their services. The only exception to the preceding policy is in situations where medical personnel employed by a licensed air ambulance provider boards an ALSI, ALSII, or BLS ground ambulance at some point, and the air ambulance medical personnel also accompany and treat the participant during the air ambulance trip. In this situation, the air ambulance provider may bill the appropriate base rate for the air ambulance trip, and may also bill the charges associated with their medical personnel and equipment as authorized by the Department. The ground ambulance provider may also bill for their part of the trip as authorized by the Department. (7-1-06)T

h. If multiple licensed EMS providers transport a participant for different legs of a trip, each provider must bill his base rate and mileage, as authorized by the Department. (7-1-06)T

i. If a licensed transporting EMS provider responds to an emergency situation and treats the participant, but does not transport the participant, the Department may reimburse for the treat and release service. The Department will reimburse the appropriate base rate. This service requires authorization from the Department, usually on a retrospective basis. (7-1-06)T

j. If an ambulance vehicle and crew have returned to a base station after having transported a participant to a facility and the participant's physician orders the participant to be transferred from this facility to another facility because of medical need, two (2) base rate charges, in addition to the mileage, will be considered for reimbursement. If an ambulance vehicle and crew do not return to a base station and the patient is transferred from one (1) facility to another facility, charges for only one (1) base rate, waiting time, and mileage will be considered. (7-1-06)T

k. Round trip charges will be allowed only in circumstances when a facility in-patient is transported to another facility to obtain specialized services not available in the facility in which the participant is an in-patient. The transport must be to and from a facility that is the nearest one with the specialized services. (7-1-06)T

l. If a licensed transporting EMS provider responds to a participant's location and upon examination and evaluation of the participant, finds that his condition is such that no treatment or transport is necessary, the Department will pay for the response and evaluation service. This service requires authorization by the Department, usually on a retrospective basis. No payment will be made if the EMS provider responds and no evaluation is done, or the participant has left the scene. No payment will be made to an EMS provider who is licensed as a non-transporting provider. (7-1-06)T

m. All ambulance providers will be reimbursed at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service as established by the Department in its pricing file. (7-1-06)T

03. Payment Subject to Third Party Liability Requirements. Before payment is made by the Department, a Medicaid participant must utilize any available insurance benefits to pay for ambulance services. (7-1-06)T

866. -- 869. (RESERVED).

870. NON-EMERGENCY TRANSPORTATION SERVICES - DEFINITIONS.

01. Commercial Transportation Provider. A commercial transportation provider is an entity in the business of transportation that is organized to provide, that publicly holds itself out to provide, and that actually provides personal transportation services to the general public. By "holding itself out" to the general public, the provider vigorously and diligently solicits riders from the general populace, as opposed to primarily serving riders from one (1) or more congregate living facilities. By "actually providing" services to the general public, the provider's riders include substantial numbers of persons whose travel is funded by a source other than Medicaid. (7-1-06)T

02. Non-Commercial Transportation Provider. Any transportation provider that does not meet the definition of a commercial transportation provider is a non-commercial transportation provider (7-1-06)T

03. Agency Transporters. Agency transporters are entities that provide transportation as well as at least one other service to one or more Medicaid participants. Individual transporters

are non-commercial providers who transport a family member, acquaintance or other person in a personal vehicle. (7-1-06)T

871. (RESERVED).

872. NON-EMERGENCY TRANSPORTATION SERVICES - COVERAGE AND LIMITATIONS.

01. General Coverage for Non-Emergency Transportation. Non-emergency transportation is all transportation that is not of an emergency nature, including non-medical transportation under waiver programs. An emergency is a condition described in Section 861 of these rules. Medicaid will reimburse non-emergency transportation by commercial or non-commercial transportation providers under the following circumstances and limitations: (7-1-06)T

a. The travel is essential to get to or from a medically necessary service or a waiver service covered by Medicaid; (7-1-06)T

b. The person for whom services are billed is actually transported for all the distance billed; (7-1-06)T

c. The mode of transportation is the lowest in cost to the Medicaid program that is appropriate to the medical needs of the participant; (7-1-06)T

d. The transportation is to the nearest medical or waiver service provider appropriate to perform the needed services, and transportation is by the most direct route practicable. Reimbursement will be limited to the distance of the most direct route practicable; and (7-1-06)T

e. Other modes of transportation, including personal vehicle, assistance by family, friends and charitable organizations, are unavailable or impractical under the circumstances; and (7-1-06)T

f. The travel is authorized by the Department prior to the transportation. (7-1-06)T

02. Exceptions. Despite the preceding rules, Medicaid will cover transportation services under the following circumstances: (7-1-06)T

a. Transportation services may be retroactively approved when a participant is found retroactively eligible, the transportation service falls within the period of retroactive eligibility, and the transporter was a Medicaid transportation provider at the time of the transport for which reimbursement is sought. (7-1-06)T

b. For Subsection 872.02 of this rule, a trip is the distance a transporter carries a participant in the course of a day. Therefore, the total mileage of a round-trip transport that takes place within one (1) day will be considered in determining whether this exception applies. Even though prior approval is not required, the transporter shall maintain all records as described in Subsection 874.02 of these rules. This exception is not available to commercial providers. (7-1-06)T

i. Agency Transporters. If the trip distance is less than twenty-one (21) miles per day, prior approval for non-commercial non waiver transport is not necessary. (7-1-06)T

ii. Individual Transportation Providers. If the trip distance is less than two hundred (200) miles one-way or four hundred (400) miles roundtrip per day, prior approval for non-commercial non waiver transport is not necessary. (7-1-06)T

c. Non-Emergency transportation for Medicaid participants who are also eligible for Medicare ("dual eligibles") when they require transportation to pick up their medications covered under Medicare, Part D. (7-1-06)T

03. Services Incidental to Travel. Medicaid will reimburse for the reasonable cost actually incurred of meals, lodging, a personal assistant and other necessary services incidental to travel, only as described in Section 873 and Subsection 875.02 of these rules. (7-1-06)T

04. Non-Commercial Transportation Provider. Non-commercial transportation services may be performed by an agency or by an individual provider. If the Medicaid participants being transported are also participants of the transportation provider for services such as residential care, mental health, developmental therapy or other services, the provider will be considered a non-commercial provider with respect to those participants, even if the provider otherwise qualifies as a commercial transporter. A provider will be considered non-commercial with respect to any Medicaid participants transported if those participants are being transported to or from another service in which the provider has any ownership or control or if the arrangement to provide transportation is not an arm's length transaction. (7-1-06)T

05. Hardship Exception for Non-Commercial Transportation Providers. The Department may grant an exception on the basis of hardship. The provider must submit information to show at minimum that its reasonable costs of vehicle operation exceed the applicable reimbursement rate. In evaluating requests for exception, the Department will consider factors such as alternative forms of services and transportation available in the area, the cost of alternatives, the appropriateness of the vehicles utilized and the benefit to participants. Special consideration may be given to any provider servicing the area through a grant from the Federal Transit Administration. The Department may limit the exception including the amount of additional reimbursement, the type of services to which transportation is being provided, and the time duration of the exception. (7-1-06)T

06. Out-of-State Transport. If payment is requested for transportation costs to receive the out-of-state medical care, the Department will determine if appropriate, comparable medical care is available closer to the participant's residence. If such care is available, the Department 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 will authorize payment for transportation costs associated with a trip to the out-of-state location. Reimbursement for transportation costs to receive out-of-state medical care requires prior authorization. (7-1-06)T

873. NON-EMERGENCY TRANSPORTATION SERVICES - PROCEDURAL REQUIREMENTS.

Authorization for the travel reimbursement must be requested from the Department at least twenty-four (24) hours in advance of the travel excluding Saturdays, Sundays, and state holidays, unless one of the exceptions described in Subsection 872.02.a. or Subsection 872.02.b. of these rules applies. (7-1-06)T

874. NON-EMERGENCY TRANSPORTATION SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

01. Commercial Transportation Providers. Each commercial transportation provider must, at minimum, meet the following standards: (7-1-06)T

a. Maintain all certifications and licenses for drivers and vehicles required by all public transportation laws, regulations, ordinances that apply to the transportation provider. (7-1-06)T

b. Adhere to all laws, rules and regulations applicable to transportation providers of that type, including those requiring liability insurance. Liability insurance will be carried in an amount to cover at least five hundred thousand dollars ($500,000) personal injury and five hundred thousand dollars ($500,000) property damage per occurrence. (7-1-06)T

c. Enter into a Medicaid provider agreement and enrollment application. (7-1-06)T

d. Each commercial provider must maintain the following records for a minimum of five (5) years. (7-1-06)T

i. Prior authorization documents. (7-1-06)T

ii. Name of participant and Medicaid ID number. (7-1-06)T

iii. Date, time, and geographical point of pick-up for each participant trip. (7-1-06)T

iv. Date, time, and geographical point of drop-off for each participant trip. (7-1-06)T

v. Identification of the vehicle(s) and driver(s) transporting each participant on each trip, and total miles for the trip. (7-1-06)T

e. Verify that all staff having contact with participants have complied with IDAPA 16.05.06, “Rules Governing Mandatory Criminal History Checks.” (7-1-06)T

02. Non-Commercial Transportation Providers. Each non-commercial transportation provider must, at minimum, meet the following standards: (7-1-06)T

a. Continuously maintain liability insurance that covers passengers. For agency providers, coverage must be at least one-hundred thousand ($100,000) per individual and three-hundred thousand ($300,000) each incident. Individual providers must carry at least the minimum liability insurance required by Idaho law. If an agency permits employees to transport participants in employees' personal vehicles, the agency must ensure that adequate insurance coverage is carried to cover those circumstances. (7-1-06)T

b. Obtain and maintain all licenses and certifications required by government to conduct business and to operate the types of vehicles used to transport participants. Agencies must maintain documentation of appropriate licensure for all employees who operate vehicles. (7-1-06)T

c. Adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used. (7-1-06)T

d. Enter into a Medicaid enrollment application and provider agreement. (7-1-06)T

e. Records. Each non-commercial transportation provider must, at the time of transport, collect the following information, and must maintain it for a minimum of five (5) years: (7-1-06)T

i. Participant name and Medicaid ID number for each trip. (7-1-06)T

ii. Date, time, geographical point of pick-up and odometer reading at pick-up for each participant trip. (7-1-06)T

iii. Date, time, geographical point of drop-off and odometer reading at drop-off for each participant trip. (7-1-06)T

iv. Mileage each participant was transported for each trip billed. (7-1-06)T

v. Identification of the vehicle and driver transporting each participant on each trip. (7-1-06)T

vi. Notice of prior authorization, when required. (7-1-06)T

875. NON-EMERGENCY TRANSPORTATION SERVICES - PROVIDER REIMBURSEMENT.

01. Submission of Transportation Claims. All transportation claims must be on a CMS 1500 Claim form and must include a trip-related authorization number where prior authorization is required. Payment must not be made in advance of the service being rendered. (7-1-06)T

02. Claims for Travel-Related Services. All claims for travel-related services must be supported by receipts, or other verification of the date, place, the amount of and the nature of services that were performed. Medicaid will not pay for claimed services that are not verifiable by contemporaneous documentation. (7-1-06)T

a. Travel covered by the service to which the participant is being transported is not reimbursable as a separate service; and (7-1-06)T

b. Transportation is paid on a reimbursement basis only; payment will not be issued prior to delivery of the service. (7-1-06)T

c. The reasonable cost of meals actually incurred in transit will be approved when necessary, when there is no other practical means of obtaining food, and only when an overnight stay is required to receive the service. Reimbursement must not exceed seven dollars ($7) per meal or a maximum of twenty-one dollars ($21) per day per person. (7-1-06)T

d. The reasonable cost actually incurred for lodging will be approved when the round trip and the needed medical service, in practicality, can not be completed in the same day. The travel must entail a one (1) way distance of at least two hundred (200) miles, or a normal one (1) way travel time of at least four (4) hours. The incidental travel expenses of a family member or other companion will be covered when medical necessity or the vulnerability of the individual requires accompaniment for safety, and no less-costly alternative is available. Lodging reimbursement will not be paid when the stay is in the home of a relative or acquaintance. (7-1-06)T

03. Commercial Transportation. A statewide uniform payment rate must be established through a study conducted no less frequently than each third year, that evaluates the actual charges of, and costs reasonably incurred by the typical commercial transportation provider, together with the reasonable administrative costs incurred by the typical provider in keeping records for Medicaid-related transportation and billing the Department. (7-1-06)T

04. Non-Commercial Providers -- Agency and Individual. (7-1-06)T

a. Agency Provider Reimbursement. A statewide uniform payment rate must be established through a study conducted no less frequently than each third year, that evaluates the actual costs reasonably incurred by the typical agency transportation provider, together with the reasonable administrative costs incurred by the typical agency transportation provider in keeping records for Medicaid-related transportation and billing the Department. (7-1-06)T

b. Individual Provider Reimbursement. A uniform payment rate must be established through a study conducted no less frequently than each third year, that evaluates the actual costs of fuel reasonably incurred by the typical non-commercial transportation provider whose personal vehicle averages fifteen (15) miles per gallon. (7-1-06)T

876. -- 879. (RESERVED).

SUB AREA S: EPSDT SERVICES
(Sections 880 Through 889)

880. (RESERVED).

881. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES (EPSDT) SERVICES - PARTICIPANT ELIGIBILITY.
EPSDT services are available to child participants from birth through the month of their twenty-first birthday. (7-1-06)T

882. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES (EPSDT) SERVICES - COVERAGE AND LIMITATIONS.

~~***01. Amount, Duration and Scope of Services**. The Department will set amount, duration, and scope of covered services. (7-1-06)T~~

~~***02. Services Must be Medically Necessary**. Needs for services discovered during an EPSDT screening that are outside the coverage provided either under this chapter of rules or under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," must be shown to be medically necessary and the least costly means of meeting the participant's medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant. (7-1-06)T~~

~~***03. Services Not Covered**. The Department will not cover services for cosmetic, convenience or comfort reasons. (7-1-06)T~~

0~~4~~1. Additional Services. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Idaho Medicaid program will not be subject to the existing amount, scope, and duration, but will be subject to the authorization requirements of those rules. ~~*The additional service must be documented by the attending physician as to why it is medically necessary and that the service requested is the least costly means of meeting the participant's medical needs. Preauthorization from the Department will be required prior to payment.* (7-1-06)T~~(7-1-06)T

***02. Services Must Be Medically Necessary**. The need for additional services must be documented by the attending physician as medically necessary. (7-1-06)T*

0~~5~~3. ~~Services Which are Least Costly~~ Prior Authorization. ~~*Those services that have not been shown or documented by the attending physician to be the least costly means of meeting the participant's medical needs are not covered and are the responsibility of the participant.*~~ *Any service requested, that is covered under Title XIX or Title XXI of the Social Security Act, that is not identified in these rules specifically as a Medicaid-covered service will require prior authorization prior to payment for that service.* ~~(7-1-06)T~~(7-1-06)T

~~***06. Prior Authorization for Medical Necessity**. Any service requested that is covered under Title XIX or Title XXI of the Social Security Act that is not identified in these rules specifically as a Medicaid-covered service will require preauthorization for medical necessity prior to payment for that service. (7-1-06)T~~

~~***07. Hearing Screens**. The Department will cover hearing screening services according to the recommended guidelines of the American Association of Pediatrics (AAP) as part of a wellness visit. The screen administered will be an age-appropriate hearing screen. (7-1-06)T~~

***04. Services Not Covered**. The Department will not cover services for cosmetic, convenience, or comfort reasons. (7-1-06)T*

0~~8~~5. Hearing ~~Services Paid~~ Aids Under EPSDT. ~~*EPSDT hearing services will pay for*~~

~~audiology services and supplies ordered by a licensed physician and supplied by a physician or licensed audiologist, in accordance with Sections 741 through 745 of these rules, with the following exceptions.~~ ~~(7-1-06)T~~(7-1-06)T

a. When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted. (7-1-06)T

b. When replacement hearing aids are requested, they may be authorized if the requirements in Subsections 741.01.a. through 741.01.d. are met. (7-1-06)T

c. The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist. (7-1-06)T

06. Eyeglasses Under EPSDT. *(7-1-06)T*

a. *In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change.* *(7-1-06)T*

b. *The Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one (1) of these reasons on his claim. If repair costs are greater than the cost of new frames, new frames may be authorized.* *(7-1-06)T*

883. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES (EPSDT) SERVICES - PROCEDURAL REQUIREMENTS.
Additional services available to a participant under EPSDT must be prior authorized by the Department. *(7-1-06)T*

~~***883. -- 887. (RESERVED).***~~

~~***888. DRUGS UNDER EPSDT.***~~
~~*Drugs not covered by the Idaho Medicaid Program may be covered under the EPSDT program under the following conditions:* *(7-1-06)T*~~

~~***01. Medically Necessary****. Must be discovered as being medically necessary by the screening services; and* *(7-1-06)T*~~

~~***02. Attending Physician****. Must be ordered by the attending physician; and* *(7-1-06)T*~~

~~***03. Authorized by Medicaid Program****. Must be authorized by the Medicaid Program prior to the purchase of the drug.* *(7-1-06)T*~~

~~***04. Experimental Drug****. May not be an experimental drug in the treatment of the child's condition.* *(7-1-06)T*~~

884. **-- 889. (RESERVED).**

SUB AREA T: SPECIFIC PREGNANCY-RELATED SERVICES
(Sections 890 Through 899)

890. PREGNANCY-RELATED SERVICES - DEFINITIONS.

01. Individual and Family Social Services. Services directed at helping a participant to overcome social or behavioral problems which may adversely affect the outcome of the pregnancy. (7-1-06)T

02. Maternity Nursing Visit. Office visits by a registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. (7-1-06)T

03. Nursing Services. Home visits by a registered nurse to assess the participant's living situation and provide appropriate education and referral during the covered period. (7-1-06)T

04. Nutritional Services. Nutritional services are described in Sections 630 through 635 of these rules. (7-1-06)T

05. Risk Reduction Follow-Up. Services to assist the participant in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. (7-1-06)T

891. (RESERVED).

892. PREGNANCY-RELATED SERVICES - COVERAGE AND LIMITATIONS.
When ordered by the participant's attending physician, nurse practitioner or nurse midwife, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs. (7-1-06)T

01. Individual and Family Social Services. Limited to two (2) visits during the covered period. (7-1-06)T

02. Maternity Nursing Visit. These services are only available to women unable to obtain a physician, NP, PA, or NM to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. (7-1-06)T

03. Nursing Services. Limited to two (2) visits during the covered period. (7-1-06)T

04. Nutrition Services. Nutritional services are described in Sections 630 through 632 of these rules. (7-1-06)T

05. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department, payment is made for qualified provider services in completion of a standard

risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care. (7-1-06)T

893. PREGNANCY-RELATED SERVICES - PROCEDURAL REQUIREMENTS.
Pregnancy-related services described in Sections 890 through 892 of these rules must be prior authorized by the Department. (7-1-06)T

894. PREGNANCY-RELATED SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

01. Risk Reduction Follow-Up. Services must be provided by licensed social workers, registered nurses, nurse midwife, physician, NP, or PA either in independent practice or as employees of entities which have current provider agreements with the Department. (7-1-06)T

02. Individual and Family Social Services. Services must be provided by a licensed social worker qualified to provide individual counseling in accordance with the provisions of IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (7-1-06)T

03. Qualified Providers of Presumptive Eligibility for Pregnant Women. The Department will enter into provider agreements allowing presumptive eligibility determination with providers meeting the qualifications of Section 1920(b)(2)(d) of the Social Security Act, and who employ individuals who have completed a course of training supplied by the Department.
. (7-1-06)T

895. PREGNANCY-RELATED SERVICES - PROVIDER REIMBURSEMENT.

01. Rates. Rate of payment for pregnancy-related services is established under the provisions of Section 230 of these rules. (7-1-06)T

02. Risk Reduction Followup Services. A single payment will be made for each month of service provided. (7-1-06)T

896. -- 899. (RESERVED).

INVESTIGATIONS, AUDITS, AND ENFORCEMENT
(Sections 900 Through 999)

SUB AREA: ESTATE RECOVERY
(Section 900)

900. LIENS AND ESTATE RECOVERY.
In accordance with Sections 56-218 and 56-218A, Idaho Code, this Section of rule sets forth the provisions for recovery of medical assistance, the filing of liens against the property of deceased persons, and the filing of liens against the property of permanently institutionalized participants. (7-1-06)T

01. Medical Assistance Incorrectly Paid. The Department may, pursuant to a

judgment of a court, file a lien against the property of a living or deceased person of any age to recover the costs of medical assistance incorrectly paid. (7-1-06)T

02. Administrative Appeals. Permanent institutionalization determination and undue hardship waiver hearings are governed by the fair hearing provisions of IDAPA 16, Title 05, Chapter 03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-06)T

03. Definitions. The following terms are applicable to Section 900 of this chapter of rules: (7-1-06)T

a. Authorized representative. The person appointed by the court as the personal representative in a probate proceeding or, if none, the person identified by the participant to receive notice and make decisions on estate matters. (7-1-06)T

b. *Discharge from a medical institution. A medical decision made by a competent medical professional that the Medicaid participant no longer needs nursing home care because the participant's condition has improved, or the discharge is not medically contraindicated.* *(7-1-06)T*

~~b~~c. Equity interest in a home. Any equity interest in real property recognized under Idaho law. (7-1-06)T

~~c~~d. Estate. All real and personal property and other assets including those in which the participant had any legal or beneficial title or interest at the time of death, to the extent of such interest, including such assets conveyed to a survivor, heir, or assignee of the deceased participant through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. (7-1-06)T

~~d~~e. Home. The dwelling in which the participant has an ownership interest, and which the participant occupied as his primary dwelling prior to, or subsequent to, his admission to a medical institution. (7-1-06)T

~~e~~f. Institutionalized participant. An inpatient in a nursing facility (NF), intermediate care facility for the mentally retarded (ICF/MR), or other medical institution, who is a Medicaid participant subject to post-eligibility treatment of income in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (7-1-06)T

~~f~~g. Lawfully residing. Residing in a manner not contrary to or forbidden by law, and with the participant's knowledge and consent. (7-1-06)T

~~g~~h. Permanently institutionalized. An institutionalized participant of any age who the Department has determined cannot reasonably be expected to be discharged from the institution and return home. Discharge refers to a medical decision made by a competent medical professional that the participant is physically able to leave the institution and return to live at home. (7-1-06)T

~~h~~i. Personal property. Any property not real property, including cash, jewelry, household goods, tools, life insurance policies, boats and wheeled vehicles. (7-1-06)T

~~i~~j. Real property. Any land, including buildings or immovable objects attached permanently to the land. (7-1-06)T

~~j~~k. Residing in the home on a continuous basis. Occupying the home as the primary dwelling and continuing to occupy such dwelling as the primary residence. (7-1-06)T

~~k~~l. Termination of a lien. The release or dissolution of a lien from property. (7-1-06)T

~~l~~m. Undue hardship. Conditions that justify waiver of all or a part of the Department's claim against an estate, described in Subsections 900.25 through 900.29 of this rule. (7-1-06)T

~~m~~n. Undue hardship waiver. A decision made by the Department to relinquish, limit, or defer its claim to any or all estate assets of a deceased participant based on good cause. (7-1-06)T

04. Notification to Department. All notification regarding liens and estate claims must be directed to the Department of Health and Welfare, Estate Recovery Unit, 3276 Elder, Suite B, P.O. Box 83720, Boise, Idaho, 83720-0036. ~~(7-1-06)T~~(7-1-06)T

05. Lien Imposed During Lifetime of Participant. During the lifetime of the permanently institutionalized participant, and subject to the restrictions set forth in Subsection 900.08 of this rule, the Department may impose a lien against the real property of the participant for medical assistance correctly paid on his behalf. The lien must be filed within ninety (90) days of the Department's final determination, after notice and opportunity for a hearing, that the participant is permanently institutionalized. The lien is effective from the beginning of the most recent continuous period of the participant's institutionalization, but not before July 1, 1995. Any lien imposed will dissolve upon the participant's discharge from the medical institution and return home. (7-1-06)T

06. Determination of Permanent Institutionalization. The Department must determine that the participant is permanently institutionalized prior to the lien being imposed. An expectation or plan that the participant will return home with the support of Home and Community Based Services does not, in and of itself, justify a decision that he is reasonably expected to be discharged to return home. The following factors must be considered when making the determination of permanent institutionalization: (7-1-06)T

a. The participant must meet the criteria for nursing facility or ICF/MR level of care and services as set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 220 through 299, and 580 through 649; (7-1-06)T

b. The medical records must be reviewed to determine if the participant's condition is expected to improve to the extent that he will not require nursing facility or ICF/MR level of care; and (7-1-06)T

c. Where the prognosis indicated in the medical records is uncertain or inconclusive, the Department may request additional medical information, or may delay the determination until the next utilization control review or annual Inspection of Care review, as appropriate. (7-1-06)T

07. Notice of Determination of Permanent Institutionalization and Hearing Rights. The Department must notify the participant or his authorized representative, in writing, of its intention to make a determination that the participant is permanently institutionalized, and that he has the right to a fair hearing in accordance with Subsection 900.02 of this rule. This notice must include the following information: (7-1-06)T

a. The notice must inform the participant that the Department's decision that he cannot reasonably be expected to be discharged from the medical institution to return home is based upon a review of the medical records and plan of care, but that this does not preclude him from returning home with services necessary to support nursing facility or ICF/MR level of care; and (7-1-06)T

b. The notice must inform the participant that he or his authorized representative may request a fair hearing prior to the Department's final determination that he is permanently institutionalized. The notice must include information that a pre-hearing conference may be scheduled prior to a fair hearing. The notice must include the time limits and instructions for requesting a fair hearing. (7-1-06)T

c. The notice must inform the participant that if he or his authorized representative does not request a fair hearing within the time limits specified, his real property, including his home, may be subject to a lien, contingent upon the restrictions in Subsection 900.08 of this rule. . (7-1-06)T

08. Restrictions on Imposing Lien During Lifetime of Participant. A lien may be imposed on the participant's real property; however, no lien may be imposed on the participant's home if any of the following is lawfully residing in such home: (7-1-06)T

a. The spouse of the participant; (7-1-06)T

b. The participant's child who is under age twenty-one (21), or who is blind or disabled as defined in 42 U.S.C. 1382c as amended; or (7-1-06)T

c. A sibling of the participant who has an equity interest in the participant's home and who was residing in such home for a period of at least one (1) year immediately before the date of the participant's admission to the medical institution, and who has been residing in the home on a continuous basis. (7-1-06)T

09. Restrictions on Recovery on Lien Imposed During Lifetime of Participant. Recovery will be made on the lien from the participant's estate, or at any time upon the sale of the property subject to the lien, but only after the death of the participant's surviving spouse, if any, and only at a time when: (7-1-06)T

a. The participant has no surviving child who is under age twenty-one (21); (7-1-06)T

b. The participant has no surviving child of any age who is blind or disabled as defined in 42 U.S.C. 1382c as amended; and (7-1-06)T

c. In the case of a lien on a participant's home, when none of the following is lawfully residing in such home who has lawfully resided in the home on a continuous basis since the date of the participant's admission to the medical institution: (7-1-06)T

i. A sibling of the participant, who was residing in the participant's home for a period of at least one (1) year immediately before the date of the participant's admission to the medical institution; or (7-1-06)T

ii. A son or daughter of the participant, who was residing in the participant's home for a period of at least two (2) years immediately before the date of the participant's admission to the medical institution, and who establishes by a preponderance of the evidence that he provided necessary care to the participant, and the care he provided allowed the participant to remain at home rather than in a medical institution. (7-1-06)T

10. Recovery Upon Sale of Property Subject to Lien Imposed During Lifetime of Participant. Should the property upon which a lien is imposed be sold prior to the participant's death, the Department will seek recovery of all medical assistance paid on behalf of the participant, subject to the restrictions in Subsection 900.09 of these rules. Recovery of the medical assistance paid on behalf of the participant from the proceeds from the sale of the property does not preclude the Department from recovering additional medical assistance paid from the participant's estate as described in Subsection 900.14 of this rule. (7-1-06)T

11. Filing of Lien During Lifetime of Participant. When appropriate, the Department will file, in the office of the Recorder of the county in which the real property of the participant is located, a verified statement, in writing, setting forth the following: (7-1-06)T

a. The name and last known address of the participant; and (7-1-06)T

b. The name and address of the official or agent of the Department filing the lien; and (7-1-06)T

c. A brief description of the medical assistance received by the participant; and (7-1-06)T

d. The amount paid by the Department, as of a given date, and, if applicable, a statement that the amount of the lien will increase as long as medical assistance benefits are paid on behalf of the participant. (7-1-06)T

12. Renewal of Lien Imposed During Lifetime of Participant. The lien, or any extension thereof, must be renewed every five (5) years by filing a new verified statement as required in Subsection 900.11 of this rule, or as required by Idaho law. (7-1-06)T

13. Termination of Lien Imposed During Lifetime of Participant. The lien will be released as provided by Idaho Code, upon satisfaction of the Department's claim. The lien will dissolve in the event of the participant's discharge from the medical institution and return home. Such dissolution of the lien does not discharge the underlying debt and the estate remains subject to recovery under estate recovery provisions in Subsections 900.14 through 900.30 of this rule. (7-1-06)T

14. Estate Recovery. In accordance Sections 56-218 and 56-218A, Idaho Code, the Department is required to recover the following: (7-1-06)T

a. The costs of all medical assistance correctly paid on or after July 1, 1995, on behalf of a participant who was permanently institutionalized; (7-1-06)T

b. The costs of medical assistance correctly paid on behalf of a participant who received medical assistance at age fifty-five (55) or older on or after July 1, 1994; and (7-1-06)T

c. The costs of medical assistance correctly paid on behalf of a participant who received medical assistance at age sixty-five (65) or older on or after July 1, 1988. (7-1-06)T

15. Recovery From Estate of Spouse. Recovery from the estate of the spouse of a Medicaid participant may be made as permitted in Sections 56-218 and *56-*218A, Idaho Code. ~~*(7-1-06)T*~~(7-1-06)T

16. Lien Imposed Against Estate of Deceased Participant. Liens may be imposed against the estates of deceased Medicaid participants and their spouses as permitted by Section 56-218, Idaho Code. (7-1-06)T

17. Notice of Estate Claim. The Department will notify the authorized representative of the amount of the estate claim after the death of the participant, or after the death of the surviving spouse. The notice must include instructions for applying for an undue hardship waiver. (7-1-06)T

18. Assets in Estate Subject to Claims. The authorized representative will be notified of the Department's claim against the assets of a deceased participant. Assets in the estate from which the claim can be satisfied must include all real or personal property that the deceased participant owned or in which he had an ownership interest, including the following: (7-1-06)T

a. Payments to the participant under an installment contract will be included among the assets of the deceased participant. This includes an installment contract on any real or personal property to which the deceased participant had a property right. The value of a promissory note, loan or property agreement is its outstanding principal balance at the date of death of the participant. When a promissory note, loan, or property agreement is secured by a Deed of Trust, the Department may request evidence of a reasonable and just underlying debt. (7-1-06)T

b. The deceased participant's ownership interest in an estate, probated or not probated, is an asset of his estate when: (7-1-06)T

i. Documents show the deceased participant is an eligible devisee or donee of property of another deceased person; or (7-1-06)T

ii. The deceased participant received income from property of another person; or (7-1-06)T

iii. State intestacy laws award the deceased participant a share in the distribution of

the property of another estate. (7-1-06)T

c. Any trust instrument which is designed to hold or to distribute funds or property, real or personal, in which the deceased participant ~~has~~ had a beneficial interest is an asset of the estate. ~~(7-1-06)T~~(7-1-06)T

d. Life insurance is considered an asset when it has reverted to the estate. (7-1-06)T

e. Burial insurance is considered an asset when a funeral home is the primary beneficiary or when there are unspent funds in the burial contract. Any funds remaining after payment to the funeral home will be considered assets of the estate. (7-1-06)T

f. Checking and savings accounts which hold and accumulate funds designated for the deceased participant, are assets of the estate, including joint accounts which accumulate funds for the benefit of the participant. (7-1-06)T

g. In a conservatorship situation, if a court order under state law specifically requires funds be made available for the care and maintenance of a participant prior to his death, absent evidence to the contrary, such funds are an asset of the deceased participant's estate, even if a court has to approve release of the funds. (7-1-06)T

h. Shares of stocks, bonds and mutual funds to the benefit of the deceased participant are assets of the estate. The current market value of all stocks, bonds and mutual funds must be proved as of the month preceding settlement of the estate claim. (7-1-06)T

19. Value of Estate Assets. The Department will use fair market value as the value of the estate assets. (7-1-06)T

20. Limitations on Estate Claims. Limits on the Department's claim against the assets of a deceased participant or spouse are subject to Sections 56-218 and 56-218A, Idaho Code. A claim against the estate of a spouse of a participant is limited to the value of the assets of the estate that had been, at any time after October 1, 1993, community property, or the deceased participant's share of the separate property, and jointly owned property. Recovery will not be made until the deceased participant no longer is survived by a spouse, a child who is under age twenty-one (21), or a blind or disabled child, as defined in 42 U.S.C. 1382c as amended and, when applicable, as provided in Subsection 900.09 of this rule. No recovery will be made if the participant received medical assistance as the result of a crime committed against the participant. (7-1-06)T

21. Expenses Deducted From Estate. The following expenses may be deducted from the available assets to determine the amount available to satisfy the Department's claim: (7-1-06)T

a. Burial expenses, which include only those reasonably necessary for embalming, transportation of the body, cremation, flowers, clothing, and services of the funeral director and staff may be deducted. (7-1-06)T

b. Other legally enforceable and necessary debts with priority may be deducted. The

Department's claim is classified and paid as a debt with preference as defined in Section 15-03-805, Idaho Code. Debts of the deceased participant that may be deducted from the estate prior to satisfaction of the Department's claim must be legally enforceable debts given preference over the Department's claim under Section 15-03-805, Idaho Code. (7-1-06)T

22. Interest on Claim. The Department's claim does not bear interest except as otherwise provided by statute or agreement. (7-1-06)T

23. Excluded Land. Restricted allotted land, owned by a deceased participant who was an enrolled member of a federally recognized American Indian tribe, or eligible for tribal membership, which cannot be sold or transferred without permission from the Indian tribe or an agency of the Federal Government, will not be subject to estate recovery. (7-1-06)T

24. Marriage Settlement Agreement or Other Such Agreement. A marriage settlement agreement or other such agreement which separates assets for a married couple does not eliminate the debt against the estate of the deceased participant or the spouse. Transfers under a marriage settlement agreement or other such agreement may be voided if not for adequate consideration. (7-1-06)T

25. Release of Estate Claims. The Department will release a claim when the Department's claim has been fully satisfied and may release its claim under the following conditions: (7-1-06)T

a. When an undue hardship waiver as defined in Subsection 900.26 of this rule has been granted; or (7-1-06)T

b. When a written agreement with the authorized representative to pay the Department's claim in thirty-six (36) monthly payments or less has been achieved. (7-1-06)T

26. Purpose of the Undue Hardship Exception. The undue hardship exception is intended to avoid the impoverishment of the deceased participant's family due to the Department exercising its estate recovery right. The fact that family members anticipate or expect an inheritance, or will be inconvenienced economically by the lack of an inheritance, is not cause for the Department to declare an undue hardship. (7-1-06)T

27. Application for Undue Hardship Waiver. An applicant for an undue hardship waiver must have a beneficial interest in the estate and must apply for the waiver within ninety (90) days of the death of the participant or within thirty (30) days of receiving notice of the Department's claim, whichever is later. The filing of a claim by the Department in a probate proceeding constitutes notice to all heirs. (7-1-06)T

28. Basis for Undue Hardship Waiver. Undue hardship waivers will be considered in the following circumstances: (7-1-06)T

a. The estate subject to recovery is income-producing property that provides the primary source of support for other family members; or (7-1-06)T

b. Payment of the Department's claim would cause heirs of the deceased participant

to be eligible for public assistance; or (7-1-06)T

c. The Department's claim is less than five hundred dollars ($500) or the total assets of the entire estate are less than five hundred dollars ($500), excluding trust accounts or other bank accounts. (7-1-06)T

d. The participant received medical assistance as the result of a crime committed against the participant. (7-1-06)T

29. Limitations on Undue Hardship Waiver. Any beneficiary of the estate of a deceased participant may apply for waiver of the estate recovery claim based on undue hardship. Any claim may be waived by the Department, partially or fully, because of undue hardship. An undue hardship does not exist if action taken by the participant prior to his death, or by his legal representative, divested or diverted assets from the estate. The Department grants undue hardship waivers on a case by case basis upon review of all facts and circumstances, including any action taken to diminish assets available for estate recovery or to circumvent estate recovery.(7-1-06)T

30. Set Aside of Transfers. Transfers of real or personal property of the participant without adequate consideration are voidable and may be set aside by the district court whether or not the asset transfer resulted, or could have resulted, in a period of ineligibility. (7-1-06)T

901. -- 909. (RESERVED).

SUB AREA: PARTICIPANT LOCK-IN
(Sections 910 Through 918)

910. PARTICIPANT UTILIZATION CONTROL PROGRAM.
This Program is designed to promote improved and cost-efficient medical management of essential health care by monitoring participant activities and taking action to correct abuses. Participants demonstrating unreasonable patterns of utilization and/or exceeding reasonable levels of utilization will be reviewed for restriction. The Department may require a participant to designate a primary physician or a single pharmacy or both for exclusive provider services in an effort to protect the individual's health and safety, provide continuity of medical care, avoid duplication of services by providers, avoid inappropriate or unnecessary utilization of medical assistance, and avoid excessive utilization of prescription medications. (7-1-06)T

911. LOCK-IN DEFINED.
Lock-in is the process of restricting the access of a participant to a specific provider or providers. (7-1-06)T

912. DEPARTMENT EVALUATION FOR LOCK-IN.
The Department will review participants to determine if services are being utilized at a frequency or amount that results in a level of utilization or a pattern of services which is not medically necessary. Evaluation of utilization patterns can include, but is not limited to, review by the Department staff of medical records and/or computerized reports generated by the Department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab and/or diagnostic procedures, hospital admissions, and referrals. (7-1-06)T

913. CRITERIA FOR LOCK-IN.
Since it is impossible to identify all possible patterns of over utilization, and since a particular pattern may be justified based on individual conditions, no specific criteria for lock-in will be developed. However, the Department may develop guidelines for purposes of uniformity. The guidelines will not be binding on the Department and will not limit or restrict the ability of the Department to impose lock-in when any pattern of over utilization is identified. The following utilization patterns may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or over utilization of Medicaid services, and may result in the restriction of Medicaid reimbursement for a participant to a single provider or providers: (7-1-06)T

01. Unnecessary Use of Providers or Services. Unnecessary use of providers or Medicaid services, including excessive provider visits. (7-1-06)T

02. Demonstrated Abusive Patterns. Recommendation from a medical professional or the participant's primary care physician that the participant has demonstrated abusive patterns and would benefit from the lock-in program. (7-1-06)T

03. Use of Emergency Room Facilities. Frequent use of emergency room facilities for non-emergent conditions. (7-1-06)T

04. Multiple Providers. Use of multiple providers. (7-1-06)T

05. Controlled Substances. Use of multiple controlled substances. (7-1-06)T

06. Prescribing Physicians or Pharmacies. Use of multiple prescribing physicians and/or pharmacies. (7-1-06)T

07. Prescription Drugs and Therapeutic Classes. Overlapping prescription drugs with the same therapeutic class. (7-1-06)T

08. Drug Abuse. Diagnosis of drug abuse or drug withdrawal, or both. (7-1-06)T

09. Drug Behavior. Drug-seeking behavior as identified by a medical professional. (7-1-06)T

10. Other Abusive Utilization. Use of drugs or other Medicaid services determined to be abusive by the Department's medical or pharmacy consultant. (7-1-06)T

914. LOCK-IN PARTICIPANT NOTIFICATION.
A participant who has been designated by the Department for the Participant Utilization Control Program will be notified in writing by the Department of the action and the participant's right of appeal by means of a fair hearing. (7-1-06)T

915. LOCK-IN PROCEDURES.

01. Participant Responsibilities. The participant will be given thirty-five (35) days to

contact the Regional Program Manager or designee and complete and sign the lock-in agreement form and select designated provider(s) in each area of misuse. (7-1-06)T

02. Appeal Stays Restriction. The Department will not implement the participant restriction if a valid appeal is noted in accordance with Section 917 of these rules. (7-1-06)T

03. Lock-In Duration. The Department will restrict participants to their designated providers for a time period determined by the Department. Upon review at the end of that period, lock-in may be extended for an additional period determined by the Department. (7-1-06)T

04. Payment to Providers. Payment to provider(s) other than the designated lock-in physician or pharmacy is limited to documented emergencies or written referrals from the primary physician. (7-1-06)T

05. Regional Programs Manager. The Regional Programs Manager, or designee will: (7-1-06)T

a. Clearly describe the participant's appeal rights in accordance with the provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings"; (7-1-06)T

b. Specify the effective date and length of the restriction; (7-1-06)T

c. Have the participant choose a designated provider or providers; and (7-1-06)T

d. Mail the completed lock-in agreement to the Surveillance and Utilization Unit. Upon receipt of the lock-in agreement, the participant's Medicaid services will be immediately restricted to the designated provider(s). (7-1-06)T

916. PENALTIES FOR LOCK-IN NONCOMPLIANCE.
If a participant fails to respond to the notification of medical restriction(s), fails to sign the lock-in agreement, or fails to select a primary physician within the specified time period, the Medicaid benefits will be restricted to documented emergencies only. If a participant continues to abuse and/or over-utilize items or services after being identified for lock-in, the Department may terminate medical assistance benefits for a specified period of time as determined by the Department. (7-1-06)T

917. APPEAL OF LOCK-IN.
Department determinations to lock-in a participant may be appealed in accordance with the fair hearings provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," of the Department. (7-1-06)T

918. RECIPIENT EXPLANATION OF MEDICAID BENEFITS (REOMBS).

01. Monthly Surveys. The Department will conduct monthly surveys of services rendered to medical assistance participants using REOMBs. (7-1-06)T

02. Participant Response. A medical assistance participant is required to respond to

the Department's explanation of medical benefits survey whenever he is aware of discrepancies. (7-1-06)T

03. Participant Unable to Respond. If the participant is unable, because of medical or physical limitations, to respond to the survey personally, then a responsible family member or friend can respond on his behalf. (7-1-06)T

04. Medicare-to-Medicaid Cross-Over Claims. All claims processed through the cross-over system will be subject to these rules. All providers submitting cross-over claims must comply with the terms of their provider agreements. (7-1-06)T

919. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - RULES GOVERNING MEDICAID PROVIDER REIMBURSEMENT IN IDAHO

DOCKET NO. 16-0310-0601 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2007 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 56-250 through 56-257, 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 notice for the repeal of IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho" was published in the August 2, 2006, Idaho Administrative Bulletin, Vol. 06-8, page 285. The rewritten chapter that replaced it, IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" published simultaneously under Docket No. 16-0310-0602.**

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Pam Mason at (208) 364-1863.

DATED this 6th day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2006.

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 Sections 56-202(b), and 56-250 through 56-257, Idaho Code. These rule changes are being made to bring this chapter of rules into compliance with HB 776 (2006) - "Medicaid Modernization and Simplification Act," also, HCR 51 and HCR 52 (passed by the 2006 Legislature).

DEPARTMENT OF HEALTH & WELFARE ***Docket No. 16-0310-0601***
Rules Governing Medicaid Provider Reimbursement ***PENDING RULE***

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

Date:	**Wednesday, August 16, 2006**	**Thursday, August 17, 2006**	**Tuesday, August 22, 2006**
Time:	**7:00 p.m.**	**7:00 p.m.**	**7:00 p.m.**
Place:	**Idaho Falls Public Library** **457 Broadway** **Idaho Falls, ID** **Phone: (208) 612-8455**	**Coeur d'Alene Inn** **Hayden Conference Room** **506 W Appleway Ave.** **Coeur d'Alene, ID**	**DHW - Region IV Office** **1720 Westgate Dr.** **Suite D, Room 119** **Boise, 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 nontechnical explanation of the substance and purpose of the proposed rulemaking: This entire chapter of rules is being repealed. The text of the rewritten chapter IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," appears under Docket No. 16-0310-0602 that is being published simultaneously with this docket and has the same effective date.

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

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes to rule are being made to implement legislation passed during the 2006 legislative session.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Pam Mason at (208) 364-1863.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, August 23, 2006.

DATED this 20th day of June, 2006.

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 16.03.10 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0602 (CHAPTER REWRITE)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: **The effective date of the amendment to the temporary rule is July 1, 2006, October 1, 2006, and January 1, 2007.** This pending rule has been adopted by the agency and is now pending review by the 2007 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), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code and Title XIX and Title XXI of the Social Security Act, as amended, and the companion federal regulations.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the 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 following is an overview of amendments made to the pending rule, based on input received during the public comment period. The changes to these rules are:

1. **Modified the definitions for clarification, added definitions for terms used in the chapter and deleted definitions for terms not used in the chapter;**
2. **Clarified when individuals may provide service on a provisional basis when a criminal history check is required;**
3. **Moved the requirements for participation in the costs of Home and Community Based Waiver Services (HCBS) to the new chapter of rules, IDAPA 16.03.18, "Medicaid Cost-Sharing";**
4. **Added a section regarding the Medicare Saving Program that was inadvertently left out of the rewrite of the chapter;**
5. **Added sections for accounting principles and provider reimbursement to reflect practices that have long been in effect, that include general fees, interest charges, final payments, retroactive adjustments, recovery methods and related party transactions;**
6. **Clarified the enhanced plan services for the following: mental health outpatient services, psychosocial rehabilitative services (PSR) and provider responsibilities, school-based services and reimbursement procedures, nursing facility services and reimbursement procedures, Intermediate Care Facility for Persons With Mental Retardation (ICF/MR) services and reimbursement procedures; developmental disabilities agency services; residential habilitation services and service coordination services;**

7. **Corrected citations, made typographical, transcriptional and other clerical corrections as needed.**

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 from the proposed text are printed in this bulletin. The original text of the proposed rule was published in the August 2, 2006 Idaho Administrative Bulletin, Vol. 06-8, pages 286 through 466.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Pam Mason at (208) 364-1863.

DATED this 14th day of November, 2006.

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: **The effective dates of the temporary rule are April 7, 2005; May 1, 2006; July 1, 2006; and October 1, 2006.**

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 Sections 56-202(b), and 56-250 through 56-257, Idaho Code. These rule changes are being made to bring this chapter of rules into compliance with HB 776 "Medicaid Modernization and Simplification Act," and, HCR 51 and HCR 52 approved by the 2006 Legislature. The Medical Assistance programs are under Title XIX and Title XXI of the Social Security Act.

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

Date:	**Wednesday, August 16, 2006**	**Thursday, August 17, 2006**	**Tuesday, August 22, 2006**
Time:	**7:00 p.m.**	**7:00 p.m.**	**7:00 p.m.**
Place:	**Idaho Falls Public Library** **457 Broadway** **Idaho Falls, ID** **Phone: (208) 612-8455**	**Coeur d'Alene Inn** **Hayden Conference Room** **506 W Appleway Ave.** **Coeur d'Alene, ID**	**DHW - Region IV Office** **1720 Westgate Dr.** **Suite D, Room 119** **Boise, 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 nontechnical explanation of the substance

and purpose of the proposed rulemaking:

As part of the implementation of the "Medicaid Modernization and Simplification Act" (HB 776), approved by the 2006 Legislature, the Department has rewritten the IDAPA 16.03.10, "Medicaid Provider Reimbursement" chapter of rules and it is now called the "Medicaid Enhanced Plan Benefits" chapter. This rule will incorporate Medicaid benefits reflected in Idaho law that meet the health needs of adults and children who are disabled, or have special needs not covered under the Medicaid Basic Plan. This restructuring of the chapter will provide services and benefits based on the participant's health needs, disabilities, or special needs in order to better serve Idaho's most needy citizens.

This chapter will also allow the Department to contract with a limited number of providers for selected services and supplies to increase Medicaid's purchasing power to implement HCR 51 adopted by the 2006 Legislature.

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

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes to the rules are being made to implement legislation passed during the 2006 legislative session.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Pam Mason at (208) 364-1863.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, August 23, 2006.

DATED this 29th day of June, 2006.

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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THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16
TITLE 03
CHAPTER 10

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

000. LEGAL AUTHORITY.

01. ***Rulemaking Authority***. The Idaho Department of Health and Welfare has the authority to promulgate *public assistance* rules *under* Section~~s~~ 56-202(b)~~ *and 56-203(g)*~~, Idaho Code. (7-1-06)T

02. ***General Administrative Authority***. Title XIX and Title XXI, ~~*Medicaid Program,*~~ of the Social Security Act, as amended, ~~*is*~~ *and the companion federal regulations, are* the basic authority for administration of the federal program~~ *under 42 CFR Part 447. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for in-state providers*~~. *General administrative duties for the Department are found under* Section 56-202, Idaho Code~~*, provides that the Department is responsible for administering the program*. *Further it authorizes the Department to take necessary steps for its proper and efficient administration.*~~ ~~*(7-1-06)T*~~(7-1-06)T

03. ***Administration of the Medical Assistance Program***. *(7-1-06)T*

a. *Section 56-203(g), Idaho Code, empowers the Department to define persons entitled to medical assistance.* *(7-1-06)T*

b. *Section 56-203(i), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program.* *(7-1-06)T*

c. *Sections 56-250 through 56-257, Idaho Code, establish minimum standards that enable these rules.* *(7-1-06)T*

0~~1~~*4*. ~~***General***~~ ***Fiscal Administration***. ~~*(7-1-06)T*~~(7-1-06)T

a. Fiscal administration of the*se* ~~*Idaho*~~ *rules is authorized by* Title XIX and Title XXI ~~*Medicaid Program will be in accordance with these rules*~~ *of the Social Security Act,* as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2~~,~~*.* ~~*which are*~~ *Provisions of the PRM, as* incorporated by reference in Section 004 of these rules~~.~~*,* ~~*The provisions will*~~ apply unless otherwise ~~*authorized*~~ *provided for in these rules*. ~~*(7-1-06)T*~~(7-1-06)T

b. ~~*Generally accepted accounting principles, concepts and definitions are followed in determining acceptable accounting treatments except as otherwise provided.*~~ *Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers.* ~~*(7-1-06)T*~~(7-1-06)T

~~**02. Compliance as Condition of Participation**. Compliance with the provisions in this chapter, its amendments, and additions is required for participation in the Idaho Title XIX and Title XXI Medicaid Program. (7-1-06)T~~

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-06)T

02. Scope. These rules establish the Medicaid Enhanced Plan Benefits covered under Title XIX and Title XXI. Participants who are eligible for Enhanced Plan Benefits are also eligible for benefits under IDAPA 16.03.09 "Medicaid Basic Plan Benefits." (7-1-06)T

03. Scope of Reimbursement System Audits. These rules also provide for the audit of providers' claimed costs against these rules and Medicare standards. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records: (7-1-06)T

a. Cost verification of actual costs for providing goods and services; (7-1-06)T

b. Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; (7-1-06)T

c. Effectiveness of the service to achieve desired results or benefits; and (7-1-06)T

d. Reimbursement rates or settlement calculated under this chapter. (7-1-06)T

04. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." (7-1-06)T

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection as described in Sections 005 and 006 of these rules. (7-1-06)T

003. ADMINISTRATIVE APPEALS.
Administrative appeals are governed by IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-06)T

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following documents: (7-1-06)T

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations internet site at http://www.access.gpo.gov/nara/cfr/cfr-table-

search.html. (7-1-06)T

02. 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. (7-1-06)T

03. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (7-1-06)T

04. Medicare Region D Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual or Its Successor. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X, date April 2001, is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (7-1-06)T

05. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2), is available on the CMS internet site at http://cms.hhs.gov/manuals/pub151/PUB_15_1.asp and http://cms.hhs.gov/manuals/pub152/PUB_15_2.asp. (7-1-06)T

06. Resource Utilization Groups (RUG) Grouper. The RUG III, version 5.12, 34 Grouper, nursing weights only, with index maximization. The RUG Grouper is available from CMS, 7500 Security Blvd., Baltimore, MD, 21244-1850. (7-1-06)T

07. SIB-R Comprehensive Manual. Scales of Independent Behavior - Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. (7-1-06)T

08. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.state.id.us. (7-1-06)T

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

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. (7-1-06)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (7-1-06)T

03. Street Address. The business office of the Idaho Department of Health and

Welfare is located at 450 West State Street, Boise, Idaho 83702. (7-1-06)T

04. Telephone. (208) 334-5500. (7-1-06)T

05. Internet Website Address. The website address is: "http://www.healthandwelfare.idaho.gov". (7-1-06)T

06. Division of Medicaid. The Division of Medicaid is located at 3232 Elder Street, Boise Idaho, 83705; Phone: (208) 334-5747. (7-1-06)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUEST.

01. Confidentiality of Records. Information received by the Department is subject to the provisions of IDAPA 16.05.01, "Use and Disclosure of Department Records," for the following records. (7-1-06)T

a. A provider's reimbursement records. (7-1-06)T

b. An individual's records covered by these rules. (7-1-06)T

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (7-1-06)T

007. (RESERVED).

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse or Misconduct." (7-1-06)T

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Agencies must verify that individuals working in the area listed in Section 009.04 of these rules whom are employed or whom they contract has complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." (7-1-06)T

02. Availability to Work or Provide Service. ~~*Certain individuals are allowed to provide services after the self-declaration and fingerprinting is received by the Department, except when they have disclosed a designated crime listed in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." The criminal history check requirements applicable to each provider type are found in the rules that state the qualifications of those providers.*~~
~~*(7-1-06)T*~~(1-1-07)T

a. *The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is*

completed and notarized and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant record. *(1-1-07)T*

b. *Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department.* *(1-1-07)T*

03. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (7-1-06)T

04. Providers Subject to Criminal History and Background Check Requirements. The following providers are required to have a criminal history and background check: (7-1-06)T

a. Adult Day Care Providers. The criminal history and background check requirements applicable to providers of adult day care as provided in Section 705 of these rules. (7-1-06)T

b. Certified Family Home Providers and All Adults in the Home. The criminal history and background check requirements applicable to certified family homes are found in Subsection~~*s 341.01 and*~~ 705.01 of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." ~~*(7-1-06)T*~~(7-1-06)T

c. Developmental Disabilities Agencies (DDA). The criminal history and background check for DDA and staff as provided in IDAPA 16.04.11, "Rules Governing Developmental Disabilities Agencies," Section~~*s 301 and 761*~~ *009*. ~~*(7-1-06)T*~~(7-1-06)T

d. Mental Health Clinics. The criminal history and background check requirements applicable to mental health clinic staff as provided in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 714. (7-1-06)T

e. Personal Assistance Agencies Acting As Fiscal Intermediaries. The criminal history and background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries as provided in Subsection 329.02 of these rules. (7-1-06)T

f. Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. (7-1-06)T

g. Psychosocial Rehabilitation Agencies. The criminal history and background check requirements applicable to psychosocial rehabilitation agency employees as provided in Subsection 130.02 of these rules. (7-1-06)T

h. Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 705 of these

rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301. (7-1-06)T

i. Service Coordinators And Paraprofessionals. The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules. (7-1-06)T

010. DEFINITIONS A THROUGH D.

For the purposes of these rules, the following terms are used as defined below: *(7-1-06)T*

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (7-1-06)T

02 Active Treatment. Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a qualified mental retardation professional (QMRP) directed toward: the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or the prevention or deceleration of regression or loss of current functional status. (7-1-06)T

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. (7-1-06)T

04. Allowable Cost. Costs that are reimbursable, and sufficiently documented to meet the requirements of audit. (7-1-06)T

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (7-1-06)T

06. Appraisal. The method of determining the value of property as determined by an American Institute of Real Estate Appraiser (MAI) appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (7-1-06)T

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (7-1-06)T

08. 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 instrumental activities of daily living (IADL). 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. (7-1-06)T

09. **Audit**. An examination of ~~*facility*~~ *provider* records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements *and records* with Medicaid law, regulations, and rules. ~~*(7-1-06)T*~~(7-1-06)T

10. **Auditor**. The individual or entity designated by the Department to conduct the audit of a provider's records. (7-1-06)T

11. **Audit Reports**. (7-1-06)T

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (7-1-06)T

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (7-1-06)T

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (7-1-06)T

12. **Bad Debts**. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (7-1-06)T

13. **Bed-Weighted Median**. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (7-1-06)T

~~***14.*** ***Beneficiaries****. Persons who are eligible for and receive benefits under federal health insurance programs such as Title XVIII, Title XIX, and Title XXI.* *(7-1-06)T*~~

~~***15.*** ***Betterments****. Improvements to assets which increase their utility or alter their use.* *(7-1-06)T*~~

~~***16.*** ***Buy-In Coverage****. The amount the State pays for Part B of Title C XVIII on behalf of the participant.* *(7-1-06)T*~~

1~~7~~4. **Capitalize**. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (7-1-06)T

1~~8~~5. **Case Mix Adjustment Factor**. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average *nursing* facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average *nursing* facility-wide acuity is the average of the indexes that correspond to the cost reporting period. ~~*(7-1-06)T*~~(7-1-06)T

1~~9~~6. **Case Mix Index (CMI)**. A numeric score assigned to each *nursing* facility

resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. ~~(7-1-06)T~~(7-1-06)T

a. *Nursing* Facility Wide Case Mix Index. The average of the entire *nursing* facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. ~~(7-1-06)T~~(7-1-06)T

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (7-1-06)T

c. State-Wide Average Case Mix Index. The simple average of all *nursing* facilities "facility wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. ~~(7-1-06)T~~(7-1-06)T

~~20~~17. Certified Family Home. A home certified by the Department to provide care to one (1) or two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence. (7-1-06)T

~~21~~8. Chain Organization. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (7-1-06)T

~~22~~19. Claim. An itemized bill for services rendered to one (1) participant by a provider *and* submitted ~~on any of the following~~ *to the* Department ~~claim forms~~ *for payment*. ~~(7-1-06)T~~(7-1-06)T

***20. Clinical Nurse Specialist**. A licensed professional nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-06)T*

2~~3~~1. Collateral Contact~~s~~. Contact~~s~~ 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. ~~(7-1-06)T~~(7-1-06)T

2~~4~~2. Common Ownership. An individual, individuals, or other entities who have equity or ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (7-1-06)T

2~~5~~3. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (7-1-06)T

2~~6~~4. Control. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (7-1-06)T

2~~7~~5. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. (7-1-06)T

2~~8~~6. Cost Component. The portion of the *nursing* facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a *nursing* facility's rate is established annually at July 1st of each year. ~~*(7-1-06)T*~~(7-1-06)T

2~~9~~7. Cost Reimbursement System. A method of fiscal administration of Title XIX and Title XXI which compensates the provider on the basis of expenses incurred. (7-1-06)T

~~30~~28. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (7-1-06)T

~~31~~29. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (7-1-06)T

3~~2~~0. Costs Related to Patient Care. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include, but are not limited to, costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (7-1-06)T

3~~3~~1. Costs Not Related to Patient Care. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are nonallowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (7-1-06)T

3~~4~~2. Customary Charges. Customary charges are the rates charged to Medicare ~~*beneficiaries*~~ *participants* and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. ~~*(7-1-06)T*~~(7-1-06)T

3~~5~~3. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the ~~*provider*~~

Intermediate Care Facility for the Mentally Retarded (ICF/MR). However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. ~~(7-1-06)T~~(7-1-06)T

3~~6~~4. Department. The ~~state of~~ Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. ~~(7-1-06)T~~(7-1-06)T

3~~7~~5. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (7-1-06)T

3~~8~~6. Developmental Disability (DD). A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age; and (7-1-06)T

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; (7-1-06)T

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (7-1-06)T

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (7-1-06)T

3~~9~~7. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (7-1-06)T

a. Direct nursing salaries that include the salaries of professional nurses (RN), licensed professional nurses, certified nurse's aides, and unit clerks; (7-1-06)T

b. Routine nursing supplies; (7-1-06)T

c. Nursing administration; (7-1-06)T

d. Direct portion of Medicaid related ancillary services; (7-1-06)T

e. Social services; (7-1-06)T

f. Raw food; (7-1-06)T

g. Employee benefits associated with the direct salaries: and (7-1-06)T

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (7-1-06)T

~~40~~38. **Director**. The Director of the Department of Health and Welfare or his designee. (7-1-06)T

~~41~~39. **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 medical assistance participant. (7-1-06)T

011. DEFINITIONS E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: *(7-1-06)T*

01. Educational Services. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services**;** and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (7-1-06)T

02. Eligibility Rules. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (7-1-06)T

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (7-1-06)T

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (7-1-06)T

b. Serious impairment to bodily functions. (7-1-06)T

c. Serious dysfunction of any bodily organ or part. (7-1-06)T

04. ***Enhanced Plan****. The medical assistance benefits included under this chapter of rules.* *(7-1-06)T*

05. ***EPSDT****. Early and Periodic Screening Diagnosis and Treatment.* *(7-1-06)T*

0~~4~~6. **Equity**. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (7-1-06)T

0~~5~~7. **Facility**. Facility refers to a *hospital,* nursing facility, or an intermediate care facility for persons with mental retardation. ~~*(7-1-06)T*~~(7-1-06)T

a. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital. (7-1-06)T

b. "Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)" means ~~*a facility licensed as an ICF/MR and federally certified to provide care to Medicaid and Medicare patients*~~ *an entity as defined in Subsection 011.29 in this rule*. ~~*(7-1-06)T*~~(7-1-06)T

c. "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (7-1-06)T

d. Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. (7-1-06)T

e. "Urban Hospital-Based Nursing Facilities" means hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (7-1-06)T

0~~6~~8. **Fiscal Year**. An accounting period that consists of twelve (12) consecutive months. (7-1-06)T

0~~7~~9. **Forced Sale**. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (7-1-06)T

~~08~~10. **Funded Depreciation**. Amounts deposited or held which represent recognized depreciation. (7-1-06)T

~~09~~11. **Generally Accepted Accounting Principles (GAAP)**. A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (7-1-06)T

1~~0~~2. **Goodwill**. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (7-1-06)T

~~***11.*** ***Health Authority****. An authorized official of any of the seven (7) Idaho District Health Departments or their satellite centers.* *(7-1-06)T*~~

13. ***Healthy Connections****. The primary care case management model of managed care under Idaho Medicaid.* *(7-1-06)T*

1~~2~~4. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (7-1-06)T

1~~3~~5. ICF/MR Living Unit. The physical structure that an ICF/MR uses to house patients. (7-1-06)T

1~~4~~6. Improvements. Improvements to assets which increase their utility or alter their use. (7-1-06)T

1~~5~~7. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (7-1-06)T

a. Activities; (7-1-06)T

b. Administrative and general care costs; (7-1-06)T

c. Central service and supplies; (7-1-06)T

d. Dietary (non-"raw food" costs); (7-1-06)T

e. Employee benefits associated with the indirect salaries; (7-1-06)T

f. Housekeeping; (7-1-06)T

g. Laundry and linen; (7-1-06)T

h. Medical records; (7-1-06)T

i. Other costs not included in direct care costs, or costs exempt from cost limits; and (7-1-06)T

j. Plant operations and maintenance (excluding utilities). (7-1-06)T

1~~6~~8. Inflation Adjustment. The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (7-1-06)T

1~~7~~9. Inflation Factor. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. (7-1-06)T

~~18~~20. **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. (7-1-06)T

~~19~~21. **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: (7-1-06)T

a. At least one (1) registered nurse; and (7-1-06)T

b. One (1) qualified mental retardation professional; and when required, one (1) of the following: (7-1-06)T

i. A consultant physician; or (7-1-06)T

ii. A consultant social worker; or (7-1-06)T

iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (7-1-06)T

2~~0~~2. **Instrumental Activities of Daily Living (IADL)**. Those activities performed in supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (7-1-06)T

2~~1~~3. **Interest**. The cost incurred for the use of borrowed funds. (7-1-06)T

2~~2~~4. **Interest on Capital Indebtedness**. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. (7-1-06)T

2~~3~~5. **Interest on ~~Current Indebtedness~~ Working Capital**. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are reported under administrative costs. ~~(7-1-06)T~~(7-1-06)T

2~~4~~6. **Interest Rate Limitation**. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/MR facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. (7-1-06)T

2~~5~~7. **Interim Reimbursement Rate (IRR)**. A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (7-1-06)T

2~~6~~8. **Intermediary**. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (7-1-06)T

2~~7~~9. Intermediate Care Facility for Persons with Mental Retardation (ICF/MR). ~~*An intermediate care facility whose primary purpose is to provide habilitative services and maintain optimal health status for individuals with mental retardation or persons with related conditions.*~~ *An entity licensed as an ICF/MR and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities.* ~~*(7-1-06)T*~~(7-1-06)T

~~28~~30. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. *Premiums related to keyman insurance are not allowable.* ~~*(7-1-06)T*~~(7-1-06)T

012. DEFINITIONS L THROUGH O.
For the purposes of these rules, the following terms are used as defined below: *(7-1-06)T*

01. Lease. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (7-1-06)T

02. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (7-1-06)T

03. 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. (7-1-06)T

04. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (7-1-06)T

05. Licensed Bed Capacity. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (7-1-06)T

06. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (7-1-06)T

07. Lower of Cost or Charges. Payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public) is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge are reimbursed fair compensation; which is the same as reasonable cost. (7-1-06)T

08. MAI Appraisal. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (7-1-06)T

09. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (7-1-06)T

a. A relatively fixed location in the building; (7-1-06)T

b. Capable of being moved, as distinguished from building equipment; (7-1-06)T

c. A unit cost of five thousand dollars ($5000) or more; (7-1-06)T

d. Sufficient size and identity to make control feasible by means of identification tags; and (7-1-06)T

e. A minimum life of three (3) years. (7-1-06)T

10. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (7-1-06)T

11. Medicaid. Idaho's Medical Assistance Program. (7-1-06)T

12. Medicaid Related Ancillary Costs. For the purpose of these rules, those services *provided in nursing facilities* considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. ~~*(7-1-06)T*~~(7-1-06)T

13. Medical Care Treatment Plan. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (7-1-06)T

14. Medical Necessity *(Medically Necessary)*. A service is medically necessary if: ~~*(7-1-06)T*~~(7-1-06)T

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (7-1-06)T

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (7-1-06)T

c. Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (7-1-06)T

15. 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. (7-1-06)T

16. ***Medicare Savings Program****. The program formerly known as "Buy-In Coverage," where the state pays the premium amount for participants eligible for Medicare Parts A and B of Title XVIII.* *(7-1-06)T*

1~~6~~7. Minimum Data Set (MDS). A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (7-1-06)T

1~~7~~8. Minor Movable Equipment. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen may, at the facility's option, be considered minor movable equipment with the cost reported as a medical supply. The general characteristics of this equipment are: (7-1-06)T

a. No fixed location and subject to use by various departments of the provider's facility; (7-1-06)T

b. Comparatively small in size and unit cost under five thousand dollars ($5000); (7-1-06)T

c. Subject to inventory control; (7-1-06)T

d. Fairly large quantity in use; and (7-1-06)T

e. A useful life of less than three (3) years. (7-1-06)T

1~~8~~9. Necessary. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (7-1-06)T

~~19~~20. **Negotiated Service Agreement** (NSA). The plan reached by the resident and his representative, or both, and the facility or certified family home based on the assessment, physician or authorized provider's orders, admissions records, and desires of the resident. The NSA must outline services to be provided and the obligations of the facility or certified family home and the resident. (7-1-06)T

2~~0~~1. Net Book Value. The historical cost of an asset, less accumulated depreciation. (7-1-06)T

2~~1~~2. New Bed. Subject to specific exceptions stated in these rules, a bed is considered new if it adds to the number of beds for which a *nursing* facility is licensed on or after July 1, 1999. ~~*(7-1-06)T*~~(7-1-06)T

2~~2~~3. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (7-1-06)T

2~~3~~4. Nonambulatory. Unable to walk without assistance. (7-1-06)T

2~~4~~5. Nonprofit Organization. An organization whose purpose is to render services without regard to gains. (7-1-06)T

2~~5~~6. Normalized Per Diem Cost. Refers to direct care costs that have been adjusted based on the *nursing* facility's case mix index for purposes of making the per diem cost comparable among *nursing* facilities. Normalized per diem costs are calculated by dividing the *nursing* facility's direct care per diem costs by its *nursing* facility-wide case mix index, and multiplying the result by the statewide average case mix index. ~~(7-1-06)T~~(7-1-06)T

2~~6~~7. Nurse Practitioner. A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-06)T

2~~7~~8. Nursing Facility (NF). An institution, or distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services for participants. *It must be an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants.* The participant must require medical or nursing care, or rehabilitation services for injuries, disabilities, or illness. ~~(7-1-06)T~~(7-1-06)T

2~~8~~9. Nursing Facility Inflation Rate. See the definition of Inflation Factor in Subsection 011.17 of these rules. (7-1-06)T

~~29~~30. Ordinary. Ordinary means that the costs incurred are customary for the normal operation of the business. (7-1-06)T

3~~0~~1. 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. (7-1-06)T

013. DEFINITIONS P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: *(7-1-06)T*

01. Patient Day. *For a nursing facility or an ICF/MR,* a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care will be deemed to exist. ~~(7-1-06)T~~(7-1-06)T

02. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (7-1-06)T

03. Patient. The person undergoing treatment or receiving services from a provider. (7-1-06)T

04. 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. (7-1-06)T

05. Personal Assistance Services (PAS). Services that include attendant care and personal care services. (7-1-06)T

06. 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. (7-1-06)T

07. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." (7-1-06)T

08. Picture Date. A point in time when case mix indexes are calculated for every *nursing* facility based on the residents in the *nursing* facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the *nursing* facility's rate for the next quarter. ~~*(7-1-06)T*~~(7-1-06)T

09. Plan of Care. A written description of medical, remedial, 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. (7-1-06)T

10. Private Rate. Rate most frequently charged to private patients for a service or item. (7-1-06)T

11. PRM. The Provider Reimbursement Manual. (7-1-06)T

12. Property. The homestead and all personal and real property in which the participant has a legal interest. (7-1-06)T

13. Property Costs. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (7-1-06)T

14. Property Rental Rate. A rate paid per Medicaid patient day to ~~*other than hospital based*~~ *free-standing* nursing facilities *and ICF/MRs* in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/MR facilities. ~~*(7-1-06)T*~~(7-1-06)T

15. Provider. Any individual, *partnership, association, corporation or* organization, ~~*or business entity*~~ ~~*furnishing*~~ *public or private, that furnishes* medical goods or services in compliance with ~~*this chapter*~~ *these rules and* who has *applied for and received* a Medicaid

provider number and has entered into a written provider agreement with the Department *in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205*.
~~*(7-1-06)T*~~(7-1-06)T

16. Provider Agreement. An written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (7-1-06)T

17. Provider Reimbursement Manual (PRM). The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, which are incorporated by reference in Section 004 of these rules. (7-1-06)T

~~***18. Prudent Buyer**. A prudent buyer is one who seeks to minimize cost when purchasing an item of standard quality or specification, PRM, Chapter 2100.* *(7-1-06)T*~~

1~~9~~8. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-06)T

~~20~~19. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (7-1-06)T

2~~1~~0. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (7-1-06)T

~~***22. 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)."* *(7-1-06)T*~~

2~~3~~1. Raw Food. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (7-1-06)T

2~~4~~2. Reasonable Property Insurance. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (7-1-06)T

2~~5~~3. 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.). (7-1-06)T

2~~6~~4. Regional Medicaid Services (RMS). *Regional offices of the Division of Medicaid.* ~~(7-1-06)T~~(7-1-06)T

2~~7~~5. Regional Nurse Reviewer (RNR). A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (7-1-06)T

***26.* Registered Nurse - R.N**. *Which in the state of Idaho is known as a Licensed Professional Nurse and who meets all the applicable requirements to practice as a licensed professional nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing."* *(7-1-06)T*

2~~8~~7. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider (7-1-06)T

2~~9~~8. Related to Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (7-1-06)T

~~30~~29. Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Care or Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (7-1-06)T

3~~1~~0. Resource Utilization Groups (RUG). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting. (7-1-06)T

3~~2~~1. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (7-1-06)T

3~~3~~2. 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. (7-1-06)T

3~~4~~3. Speech/Language Pathology and Audiology Services. Diagnostic, screening, preventative, or corrective services provided by a licensed 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. (7-1-06)T

3~~5~~4. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (7-1-06)T

3~~6~~5. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (7-1-06)T

3~~7~~6. Title XVIII. ~~*The*~~ *Title XVIII of the Social Security Act, known as* Medicare, ~~*program*~~ for the aged, blind, and disabled administered ~~*under the Social Security Act*~~ *by the federal government*. ~~*(7-1-06)T*~~(7-1-06)T

3~~8~~7. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (7-1-06)T

3~~9~~8. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (7-1-06)T

~~40~~39. 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. (7-1-06)T

4~~1~~0. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (7-1-06)T

4~~2~~1. Uniform Assessment. A set of standardized criteria to assess functional and cognitive abilities. (7-1-06)T

4~~3~~2. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 "Rules Governing Uniform Assessments of State-Funded Clients." (7-1-06)T

4~~4~~3. Utilities. All expenses for heat, electricity, water and sewer. (7-1-06)T

4~~5~~4. 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 or participants to Title XIX and Title XXI benefits in a nursing facility. (7-1-06)T

4~~6~~5. Utilization Control Team (UCT). A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (7-1-06)T

4~~7~~6. 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. (7-1-06)T

014. -- 019. (RESERVED).

GENERAL PARTICIPANT PROVISIONS

020. PARTICIPATION IN THE COST OF WAIVER SERVICES.

01. Waiver Services and Income Limit. A participant is not required to participate in the cost of Home and Community Based (HCBS) waiver services unless: (7-1-06)T

a. The participant's eligibility for medical assistance is based on approval for and receipt of a waiver service; and (7-1-06)T

b. ~~*He would not be income eligible because of excess income if not for*~~ *The participant's income exceeds the eligibility requirement under* the HCBS income limit contained in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 787. ~~*(7-1-06)T*~~(7-1-06)T

02. ~~***Excluded Income***. *Income excluded under the provisions of IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Sections 723 and 725, is excluded in determining participation.*~~ ***Waiver Cost-Sharing***. *Participation in the cost of HCBS waiver services is determined as described in IDAPA 16.03.18, "Medicaid Cost-Sharing."* ~~*(7-1-06)T*~~(7-1-06)T

~~***03. Base Participation***. *Base participation is income available for participation after subtracting all allowable deductions, except for the incurred medical expense deduction in Subsection 020.08 of these rules. Base participation is calculated by the participant's Self Reliance Specialist. The incurred medical expense deduction is calculated by the RMS.* *(7-1-06)T*~~

~~***04. Community Spouse***. *Except for the elderly or physically disabled participant's personal needs allowance, base participation for a participant with a community spouse is calculated under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 725. These allowances are specified in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." A community spouse is the spouse of an HCBS participant who is not an HCBS participant and is not institutionalized. The HCBS personal needs allowance for a participant living in adult residential care equals the federal Supplemental Security Income (SSI) benefit rate for an individual living independently.* *(7-1-06)T*~~

~~***05. Home and Community Based Services (HCBS) Spouse***. *Except for the elderly or physically disabled participant's personal needs allowance (PNA), base participation for a participant with an HCBS spouse is calculated and specified under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 723. An HCBS spouse is the spouse of a participant who also receives HCBS.* *(7-1-06)T*~~

~~***06. Personal Needs Allowance***. *The participant's personal needs allowance depends on his marital status and legal obligation to pay rent or mortgage. The participant's personal*~~

~~needs allowance is deducted from his income after income exclusions and before other allowable deductions. To determine the amount of the personal needs allowance, use Table 020.06:~~

~~TABLE 020.06 - PERSONAL NEEDS ALLOWANCE~~			
~~Amount of Personal Needs Allowance (PNA) for Participation~~			
~~Not Responsible for Rent or Mortgage~~		~~Responsible for Rent or Mortgage~~	
~~Marital Status~~	~~PNA~~	~~Marital Status~~	~~PNA~~
~~No Spouse~~	~~One hundred percent (100%) of the federal SSI benefit for a person with no spouse~~	~~No Spouse~~	~~One hundred and fifty percent (150%) of the Federal SSI benefit for a person with no spouse~~
~~Married with Community Spouse~~	~~One hundred and fifty percent (150%) of the Federal SSI benefit for a person with no spouse~~	~~Married with Community Spouse~~	~~One hundred and fifty percent (150%) of the Federal SSI benefit for a person with no spouse~~
~~Married with HCBS Spouse~~	~~One hundred percent (100%) of the Federal SSI benefit for a person with no spouse. Each spouse receives this amount as his PNA.~~	~~Married with HCBS Spouse~~	~~One hundred and fifty percent (150%) of the Federal SSI benefit for a single person. Each spouse receives this amount as his PNA.~~

~~(7-1-06)T~~

~~**07. Developmentally Disabled or TBI Participants**. These allowances are specified in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." The HCBS personal needs allowance for adult participants receiving waiver services under the Developmentally Disabled Waiver, or the Traumatic Brain Injury (TBI) Waiver, is three (3) times the federal SSI benefit amount to an individual in his own home. (7-1-06)T~~

~~**08. Incurred Medical Expenses**. Amounts for certain limited medical or remedial services not covered by the Idaho Medicaid Plan and not paid by a third party may be deducted from the base participation amount. The Department must determine whether a participant's incurred expenses for such limited services meet the criteria for deduction. The participant must report such expenses and provide verification in order for an expense to be considered for deduction. Costs for over-the-counter medications are included in the personal needs allowance and will not be considered a medical expense. Deductions for necessary medical or remedial expenses approved by the Department will be deducted at application, and changed, as necessary, based on changes reported to the Department by the participant. (7-1-06)T~~

~~**09. Remainder After Calculation**. Any remainder after the calculation in Subsection 020.06 of these rules is the maximum participation to be deducted from the participant's provider payments to offset the cost of services. The participation amount will be collected from the participant by the provider. The provider and the participant will be notified by the Department of the amount to be collected. (7-1-06)T~~

~~**10. Recalculation of Participation**. The participant's participation amount must be recalculated annually at redetermination or whenever a change in income or deductions becomes known to the Department. (7-1-06)T~~

~~*11. Adjustment of Participation Overpayment or Underpayment Amounts. The participant's participation amount is reduced or increased the month following the participant overpaid or underpaid the provider.* (7-1-06)T~~

021. MEDICARE SAVINGS PROGRAM FOR PARTICIPANTS COVERED BY MEDICARE.
The Department has an agreement with the Centers for Medicare and Medicaid Services (CMS) to pay the premiums for Parts A and B of Title XVIII for each participant eligible for Medicare and medical assistance regardless of whether the participant receives a financial grant from the Department. (7-1-06)T

***01. AABD Effective Date**. The effective date of the Medicare Savings Program for a participant approved for medical assistance and an AABD grant is the first month of eligibility for the AABD grant.* (7-1-06)T

***02. SSI Effective Date**. The effective date of the Medicare Savings Program for a participant approved for medical assistance who also receives SSI, but not AABD, is the first month of eligibility for medical assistance.* (7-1-06)T

***03. Neither AABD or SSI Effective Date**. The effective date of the Medicare Savings Program for a participant approved for medical assistance who does not receive an AABD grant or SSI is the first day of the second month following the month in which he became eligible for medical assistance. This would mean the third month of medical assistance eligibility for the participant.* (7-1-06)T

***04. Update of Records**. After the effective date of the Medicare Savings Program it takes the Social Security Administration up to one (1) month to update its records to show the Department's payment of the Medicare Savings Program premium.* (7-1-06)T

***05. Policies for Treatment of the Medicare Savings Program**. The Department advises each participant who is paying Parts A and B Medicare premiums to discontinue payments beginning the month the Medicare Savings Program becomes effective. Policies for treatment of the Medicare Savings Program for determining eligibility for medical assistance or AABD, grant amount for AABD, or patient liability are in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)". Policies for treatment of the Medicare Savings Program for determining participation of an HCBS participant are found in Section 020 of these rules.* (7-1-06)T

02~~1~~2. PARTICIPANT'S REQUIREMENTS FOR ESTATE RECOVERY.
A participant's estate may be obligated to pay the Medicaid program back for the amount Medicaid paid out for medical assistance during the participant's life. The requirements for that estate recovery are found in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 900.
(7-1-06)T

02~~2~~3. -- 024. (RESERVED).

025. GENERAL SERVICE LIMITATIONS.

Service limitations stated in these rules include any services received by a participant under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (7-1-06)T

026. SELECTIVE CONTRACTING.
The Department may contract with a limited number of providers of certain Medicaid products and services, including: dental services, eyeglasses, transportation, and some medical supplies. (7-1-06)T

027. -- 029. (RESERVED).

GENERAL REIMBURSEMENT PROVISIONS

030. COST REPORTING.
The provider's Medicaid cost report must be filed using the Department designated reporting forms, unless the Department has approved an exception. The request to use alternate forms must be sent to the Department in writing, with samples attached, a minimum of ninety (90) days prior to the due date for the cost report. The request for approval of alternate forms cannot be used as a reason for late filing. (7-1-06)T

031. -- 03~~9~~5. (RESERVED).

036. GENERAL REIMBURSEMENT.

***01. Long-Term Care Facility Payment**. Long-term care facilities will be reimbursed the lower of their customary charges, their actual reasonable costs, or the standard costs for their class as set forth in the Provider Reimbursement Manual, but the upper limits for payment must not exceed the payment which would be determined as reasonable costs using the Title XVIII Medicare standards and principles. (7-1-06)T*

***02. Individual Provider Payment**. The Department will not pay the individual provider more than the lowest of: (7-1-06)T*

***a.** The provider's actual charge for service; or (7-1-06)T*

***b.** The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (7-1-06)T*

***c.** The Medicaid upper limitation of payment on those services, minus the Medicare payment, where a participant is eligible for both Medicare and Medicaid. The Department will not reimburse providers an amount in excess of the amount allowed by Medicaid, minus the Medicare payment. (7-1-06)T*

***03. Payment for Speech, Occupational and Physical Therapy Services**. The fees for physical, occupational, and speech therapy include the use of therapeutic equipment to provide*

the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment. *(7-1-06)T*

037. -- 038. (RESERVED).

039. ACCOUNTING TREATMENT.
Generally accepted accounting principles, concepts, and definitions will be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be the one that most clearly attains program objectives. *(7-1-06)T*

***01. Final Payment**. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. In addition, an efficiency incentive will be allowed to low cost providers in accordance with the provisions of Section 296 of these rules.* *(7-1-06)T*

***02. Overpayments**. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider.* *(7-1-06)T*

***03. Other Actions**. Generally, overpayment will result in two (2) circumstances:* *(7-1-06)T*

a. *If the cost report is not filed, the sum of the following will be due:* *(7-1-06)T*

i. *All payments included in the period covered by the missing report(s).* *(7-1-06)T*

ii. *All subsequent payments.* *(7-1-06)T*

b. *Excessive reimbursement or non-covered services may precipitate immediate audit and settlement for the period(s) in question. Where such a determination is made, it may be necessary that the interim reimbursement rate (IRR) will be reduced. This reduction will be designated to effect at least one (1) of the following:* *(7-1-06)T*

i. *Discontinuance of overpayments (on an interim basis).* *(7-1-06)T*

ii. *Recovery of overpayments.* *(7-1-06)T*

040. PROVIDER'S RESPONSIBILITY TO MAINTAIN RECORDS.
The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Subsection 001.03 of these rules. (7-1-06)T

01. Expenditure Documentation. Documentation of expenditures must include the amount, date, purpose, payee, and the invoice or other verifiable evidence supporting the expenditure. (7-1-06)T

02. Cost Allocation Process. Costs such as depreciation or amortization of assets and indirect expenses are allocated to activities or functions based on the original identity of the costs. Documentation to support basis for allocation must be available for verification. (7-1-06)T

03. Revenue Documentation. Documentation of revenues must include the amount, date, purpose, and source of the revenue. (7-1-06)T

04. Availability of Records. Records must be available for and subject to audit by the auditor, with or without prior notice, during any working day between the hours of 8:00 a.m. and 5:00 p.m. at the provider's principal place of business in the state of Idaho. (7-1-06)T

a. The provider is given the opportunity to provide documentation before the interim final audit report is issued. (7-1-06)T

b. The provider is not allowed to submit additional documentation in support of cost items after the issuance of the interim final audit report. (7-1-06)T

05. Retention of Records. Records required in Subsections 040.01 through 040.03 of these rules must be retained by the provider for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for the goods or services. (7-1-06)T

041. -- 049. (RESERVED).

050. DRAFT AUDIT REPORT.
Following completion of the audit field work *on a hospital, nursing facility, or an ICF/MR,* and before issuing the interim final audit report to the Department, the auditor will issue a draft audit report and forward a copy to the provider for review and comment. ~~*(7-1-06)T*~~(7-1-06)T

01. Review Period. The provider will have a period of sixty (60) days, beginning on the date of transmittal, to review and provide additional comments or evidence pertaining to the draft audit report. The review period may be extended when the provider: (7-1-06)T

a. Requests an extension prior to the expiration of the original review period; and (7-1-06)T

b. Clearly demonstrates the need for additional time to properly respond. (7-1-06)T

02. Evaluation of Provider's Response. The auditor will evaluate the provider's response to the draft audit report and will delete, modify, or reaffirm the original findings, as deemed appropriate, in preparing the interim final audit report. (7-1-06)T

051. FINAL AUDIT REPORT.
The auditor will incorporate the provider's response and an analysis of the response into the interim final report as appendices and transmit it to the Department. The Department will issue a final audit report and a notice of program reimbursement, if applicable, that sets forth settlement amounts due to the Department or the provider. The final audit report and notice of program reimbursement, if applicable, will take into account the findings made in the interim final audit report and the response of the provider to the draft audit report (7-1-06)T

052. -- 059. (RESERVED).

060. CRITERIA FOR PARTICIPATION IN THE IDAHO TITLE XIX AND TITLE XXI PROGRAMS.

01. Application for Participation and Reimbursement. Prior to participation in the Medical Assistance Program, facilities must be licensed or certified by the Bureau of Facility Standards, Medicaid Division, Department of Health and Welfare. The Bureau's recommendations are forwarded to the Division of Medicaid for approval for a signed provider agreement. The Department issues a provider number to the facility which becomes the primary provider identification number. The Division of Medicaid will establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued. (7-1-06)T

02. Reimbursement. The reimbursement mechanism for payment to provider facilities is specified in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate. (7-1-06)T

061. -- 069. (RESERVED).

070. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.
An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary: (7-1-06)T

01. Supplying Organization. That the supplying organization is a bona fide separate organization. (7-1-06)T

02. Nonexclusive Relationship. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. (7-1-06)T

03. Sales And Rental of Extended Care Facilities. The exception is not applicable to sales, lease or rentals of nursing homes or extended care facilities. These transactions would not meet the requirement that there be an open, competitive market for the facilities furnished. See PRM, Sections 1008 and 1012. (7-1-06)T

a. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (7-1-06)T

b. When a facility is purchased from a related entity, the purchaser's depreciable basis will not exceed the seller's net book value. See PRM, Section 1005. (7-1-06)T

COVERED SERVICES
(Sections 075 - 799)

075. ENHANCED PLAN BENEFITS - COVERED SERVICES.
Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (7-1-06)T

01. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (7-1-06)T

02. Enhanced Mental Health Benefits. Enhanced Mental Health services are provided under Sections 100 through 147 of these rules. (7-1-06)T

03. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (7-1-06)T

04. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (7-1-06)T

05. Long Term Care Services. The following services are provided under the Long Term Care Services. (7-1-06)T

a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (7-1-06)T

b. Personal Care Services as described in Sections 300 through 319of these rules. (7-1-06)T

c. A & D Wavier Services as described in Sections 320 through 335 of these rules. (7-1-06)T

d. TBI Waiver Services as described in Sections 335 through 350 of these rules. (7-1-06)T

06. Hospice. Hospice services as described in Sections 450 through 459 of these rules**.** (7-1-06)T

07. Developmental Disabilities Services. (7-1-06)T

a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (7-1-06)T

b. Behavioral Health Prior Authorization as described in Sections 507 through 520 of these rules. (7-1-06)T

c. ICF/MR as described in Sections 580 through 649 of these rules. (7-1-06)T

d. Developmental Disabilities Agencies as described in Sections 700 through 719 of

these rules. (7-1-06)T

08. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (7-1-06)T

09. Breast and Cervical Cancer Program. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (7-1-06)T

076. - 089. (RESERVED).

SUB AREA: ENHANCED HOSPITAL SERVICES
(Sections 090 Through 099)

090. ORGAN TRANSPLANTS.
The Department may reimburse for organ transplant services for bone marrows, kidneys, hearts, intestines, and livers when provided by hospitals approved by the Centers for Medicare and Medicaid for the Medicare program that have completed a provider agreement with the Department. The Department may reimburse for cornea transplants for conditions where such transplants have demonstrated efficacy. (4-7-05)T

091. - 092. (RESERVED).

093. ORGAN TRANSPLANTS - COVERAGE AND LIMITATIONS.

01. Kidney Transplants. Kidney transplant surgery will be covered only in a renal transplantation facility participating in the Medicare program after meeting the criteria specified in 42 CFR 405 Subpart U. Facilities performing kidney transplants must belong to one (1) of the End Stage Renal Dialysis (ESRD) network area's organizations designated by the Secretary of Health and Human Services for Medicare certification. (4-7-05)T

02. Living Kidney Donor Costs. The transplant costs for actual or potential living kidney donors are fully covered by Medicaid and include all reasonable preparatory, operation, and post-operation recovery expenses associated with the donation. Payments for post-operation expenses of a donor will be limited to the period of actual recovery. (7-1-06)T

03. Intestinal Transplants. Intestinal transplant surgery will be covered only for patients with irreversible intestinal failure, and who have failed total parenteral nutrition. (4-7-05)T

04. Coverage Limitations. (4-7-05)T

a. Multi-organ transplants may be covered when: (4-7-05)T

i. The primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process; and (4-7-05)T

ii. The damage to the second organ will compromise the outcome of the transplant of the primary organ. (4-7-05)T

b. Each kidney or lung is considered a single organ for transplant; (7-1-06)T

c. Re-transplants will be covered only if the original transplant was performed for a covered condition and if the re-transplant is performed in a Medicare/Medicaid approved facility; (7-1-06)T

d. A liver transplant from a live donor will not be covered by the Medical Assistance Program; (4-7-05)T

e. No organ transplants covered by the Medical Assistance Program unless prior authorized by the Department, and performed for the treatment of medical conditions where such transplants have a demonstrated efficacy. (4-7-05)T

05. Follow-Up Care. Follow-up care to a participant who received a covered organ transplant may be provided by a Medicare/Medicaid participating hospital not approved for organ transplantation. (7-1-06)T

094. -- 095. (RESERVED).

096. ORGAN TRANSPLANTS - ~~*PAYMENT METHODOLOGY*~~ *PROVIDER REIMBURSEMENT*.
Organ transplant and procurement services by facilities approved for kidneys, bone marrow, liver, or heart will be reimbursed the lesser of ninety-six and a half percent (96.5%) of reasonable costs under Medicare payment principles or customary charges. Follow-up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to Independent Organ Procurement Agencies and Independent Histocompatibility Laboratories will not be covered.
~~*(4-7-05)T*~~(4-7-05)T

097. -- 099. (RESERVED).

SUB AREA: ENHANCED MENTAL HEALTH SERVICES
(Sections 100 Through 199)

100. INPATIENT PSYCHIATRIC HOSPITAL SERVICES.
In addition to psychiatric services covered under inpatient hospital services and inpatient psychiatric hospital services covered in IDAPA 16.03.09 "Medicaid Basic Plan Benefits," the Medicaid Enhanced Plan Benefit include enhanced medically necessary services for certain individuals under the age of twenty-one (21) in free standing psychiatric hospitals (Institutions For Mental Disease). (7-1-06)T

101. (RESERVED).

102. INPATIENT PSYCHIATRIC HOSPITAL SERVICES - ELIGIBILITY.
All rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 700 through 707 apply to Inpatient Psychiatric Hospital services in this chapter of rules. (7-1-06)T

01. Limitation Exemption. The ten (10) day limitation does not apply to participants who are eligible for inpatient psychiatric hospital services under this chapter of rule. (7-1-06)T

02. Individuals Over 65. Individuals over age sixty-five (65) are eligible for inpatient psychiatric hospital services under this chapter of rule. (7-1-06)T

103. - 109. (RESERVED).

110. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES.
In addition to mental health services covered under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 710 through 717, the Medicaid Enhanced Plan Benefits includes the following enhanced outpatient mental health benefits. (7-1-06)T

01. Psychotherapy. The enhanced services include additional psychotherapy in a Mental Health Clinic as described in Subsection 115.01 of these rules. (7-1-06)T

02. Partial Care Services. The enhanced services include partial care services in a Mental Health Clinic as described in Subsection 115.02 of these rules. (7-1-06)T

03. Psychosocial Rehabilitation. The enhanced services include psychosocial rehabilitation as described in Sections 123 through 146 of these rules. (7-1-06)T

111. ENHANCED *OUTPATIENT* MENTAL HEALTH SERVICES - DEFINITIONS.
These definitions apply to Sections 100 through 146 of these rules. (7-1-06)T

01. Assessment Hours. Time allotted for completion of evaluation and diagnostic services. (7-1-06)T

02. Demographic Information. Information that identifies participants and is entered into the Department's database collection system. (7-1-06)T

03. Goal. The desired outcome related to an identified issue. (7-1-06)T

04. Initial Contact. The date a participant, parent, or legal guardian ~~signs the request for assessment hours~~ requests Enhanced Plan services. ~~(7-1-06)T~~(7-1-06)T

05. Issue. A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (7-1-06)T

06. Licensed Practitioner of the Healing Arts. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing psychotropic medication. (7-1-06)T

07. Objective. A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (7-1-06)T

08. Partial Care. Partial care is treatment for those children with serious emotional disturbance and adults with severe and persistent mental illness whose functioning is sufficiently

disrupted so as to interfere with their productive involvement in daily living. Partial care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. ~~(7-1-06)T~~(7-1-06)T

09. Psychosocial Rehabilitative Services (PSR). Rehabilitative services provided both to children with serious emotional disturbance and to adults with severe and persistent mental illness to address functional deficits due to psychiatric illness and to restore independent living, socialization, and effective life management skills. (7-1-06)T

09. Tasks. Specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan. (7-1-06)T

112. ENHANCED *OUTPATIENT* MENTAL HEALTH SERVICES - PARTICIPANT ELIGIBILITY.
In order to qualify for Enhanced *Outpatient* Mental Health Services, a participant must obtain a Comprehensive Assessment as described in Section 113 of these rules. The *comprehensive* assessment for PSR, Partial Care, and Psychotherapy must provide documentation of the medical necessity for each service to be provided. ~~(7-1-06)T~~(7-1-06)T

01. General Participant Criteria. In order for a participant to be eligible for Enhanced *Outpatient* Mental Health services, the following criteria must be met and documented: ~~(7-1-06)T~~(7-1-06)T

a. Other services have failed or are not appropriate for the clinical needs of the participant. (7-1-06)T

b. For each participant, the services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced. (7-1-06)T

c. Participants identified in the list below are disqualified from participating in Enhanced *Outpatient* Mental Health services: ~~(7-1-06)T~~(7-1-06)T

i. Persons at immediate risk of self-harm or harm to others who cannot be stabilized; (7-1-06)T

ii. Persons needing more restrictive care or inpatient care; and (7-1-06)T

iii. Persons who have not fulfilled the requirements of Subsections 112.02 or 112.03 of these rules. (7-1-06)T

02. Eligibility Criteria for Children. ~~*A seriously emotionally disturbed child is an*~~ Individual*s* under the age of eighteen (18) who ~~*has*~~ *have* a serious emotional disturbance (SED). The following definition of the SED target population is based on the definition of SED found in the Children's Mental Health Services Act, Section 16-2403, Idaho Code. ~~(7-1-06)T~~(7-1-06)T

a. Presence of an emotional or behavioral disorder, according to the DSM-IV-TR or subsequent revisions to the DSM, which results in a serious disability; and (7-1-06)T

b. Requires sustained treatment interventions; and (7-1-06)T

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (7-1-06)T

d. The disorder is considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment must be assessed using the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). Substantial impairment requires a full eight (8) scale score of eighty (80) or higher *on the CAFAS or a full seven (7) scale score of eighty (80) or higher on the PECFAS* with "moderate" impairment in at least one (1) of the following three (3) scales: ~~*(7-1-06)T*~~(7-1-06)T

i. Self-Harmful Behavior; (7-1-06)T

ii. Moods/Emotions; or (7-1-06)T

iii. Thinking. (7-1-06)T

e. A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. (7-1-06)T

03. Eligibility Criteria for Adults. ~~*A severely and persistently mentally ill adult is any*~~ Individuals eighteen (18) years or older who ~~*has*~~ *have* a severe and persistent mental illness *(SMPI)*. The following criteria are required to be a member of the target population based on the guidelines taken from the Federal Register under Section 1912(c) of the Public Health Services Act and as amended by Public Law 102-321 "adults with a serious mental illness." ~~*(7-1-06)T*~~(7-1-06)T

a. The individual must have a diagnosis under DSM-IV-TR or subsequent revisions to the DSM, of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder recurrent severe, Delusional Disorder, or Borderline Personality Disorder. The only NOS diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a more conclusive diagnosis; and (7-1-06)T

b. The psychiatric disorder must be of sufficient severity to cause a substantial disturbance in role performance or coping skills in at least two (2) of the following areas on either a continuous or an intermittent (at least once per year) basis: (7-1-06)T

i. Vocational/educational; (7-1-06)T

ii. Financial; (7-1-06)T

iii. Social relationships/support; (7-1-06)T

iv. Family; (7-1-06)T

v. Basic living skills; (7-1-06)T

vi. Housing; (7-1-06)T

vii. Community/legal; or (7-1-06)T

viii. Health/medical. (7-1-06)T

04. Participant Criteria Specific to Partial Care. The comprehensive assessment must contain further documentation showing that the participant is presently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration which would interfere with the participant's ability to maintain current level of functioning. (7-1-06)T

05. ~~*Participant Criteria Specific to PSR*~~ *Criteria Following Discharge For Psychiatric Hospitalization*. *Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules are eligible for enhanced outpatient mental health clinic and PSR services.* (7-1-06)T

a. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsection 112.02 of these rules for children, and in Subsection 112.03 of these rules for adults, are considered immediately eligible for PSR services for a period of at least one hundred and twenty (120) days following discharge from the hospital. The individualized treatment plan must be completed *and submitted to the Department for prior authorization* within ten (10) days of discharge. ~~*(7-1-06)T*~~(7-1-06)T

~~*a*~~*i*. Up to two (2) hours of plan development hours may be ~~*prior authorized*~~ for coordinating with hospital staff and others the participant chooses. These ~~*prior authorized*~~ plan development hours are to be used for the development of an individualized treatment plan based solely on the participant's hospital records and past history. The provider agency does not have to perform any additional assessment nor does the participant need to qualify as described in Subsection 113.01 of these rules. ~~*(7-1-06)T*~~(7-1-06)T

~~*b*~~*ii*. Upon submission of the completed individualized treatment plan to the Department or its designee, PSR services may be prior authorized for no more than one hundred twenty (120) days. For services to continue beyond one hundred twenty (120) days, the requirements of Section 129 of these rules must be met by the provider agency. (7-1-06)T

b. *A mental health clinic may serve a participant with Enhanced Plan services following a psychiatric hospitalization after a comprehensive assessment has been completed that has established the participant meets the criteria for Serious Emotional Disturbance (SED) or Severe and Persistent Mental Illness (SPMI). The mental health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced Plan.* *(7-1-06)T*

113. ENHANCED *OUTPATIENT* MENTAL HEALTH SERVICES - COMPREHENSIVE ASSESSMENT.

In order to determine eligibility for Enhanced *Outpatient* Mental Health services, a comprehensive assessment must first be completed. The assessment must address the participant's strengths and supports, deficits and needs, and must be directed toward formulation of a diagnosis and a written individualized treatment plan. The participant must take part in the assessment to the fullest extent possible. The assessment must be directly related to the participant's mental illness and level of functioning. Information regarding services received from any of the participant's service provider(s) must be collected and reported on the comprehensive assessment. The assessment and supplemental psychiatric, psychological, or other specialty evaluations and tests must be written, dated, signed and be retained in the participant's ~~file~~ *medical record*. The assessment is reimbursable if conducted by qualified PSR provider agency staff listed under Section 131 of these rules, or qualified Mental Health Clinic staff listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 71~~4~~*5*. Each of the following areas must be assessed initially and at least annually thereafter. ~~(7-1-06)T~~(7-1-06)T

01. Psychiatric History and Current Mental Status. Psychiatric history and current mental status which includes, at a minimum: (7-1-06)T

a. Diagnosis documented within the last twelve (12) months *in a face to face evaluation* by a licensed physician or other licensed practitioner of the healing arts, licensed master's level psychiatric nurse, licensed psychologist, licensed clinical professional counselor, licensed marriage and family therapist, or licensed clinical social worker within the scope of his practice under state law; ~~(7-1-06)T~~(7-1-06)T

b. Age of the participant at onset; (7-1-06)T

c. Childhood history of physical or sexual abuse; (7-1-06)T

d. Number of hospitalizations; (7-1-06)T

e. Precursors of hospitalizations; (7-1-06)T

f. Symptoms of decompensation the participant manifests; (7-1-06)T

g. Participant's ability to identify his symptoms; (7-1-06)T

h. Medication history; (7-1-06)T

i. Substance abuse history; (7-1-06)T

j. History of mental illness in the family; (7-1-06)T

k. Current mental status; and (7-1-06)T

l. Any other information that contributes to the assessment of the participant's current psychiatric status. (7-1-06)T

02. ***Health or*** **Medical** ~~***History And Current Medical Status***~~ ***Issues***. Medical history and current medical status which includes at a minimum, 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 or needs, current medications, name of current primary physician; *health or medical issues or both including medical complications that result from mental illness.* ~~*(7-1-06)T*~~(7-1-06)T

03. Vocational And Educational Status. Vocational and educational status which includes at a minimum, current and past job status, level of satisfaction with the vocation, educational level, military status, strengths and barriers to employment. For children, this area addresses relevant school enrollment, performance, achievement levels and school-related social functioning. (7-1-06)T

04. Financial Status. Financial status which includes at a minimum, adequacy and stability of the participant's financial status, financial difficulties of the participant, resources available, and the participant's ability to manage personal finances. (7-1-06)T

05. Social Relationships And Supports. Social relationships and supports which includes, at a minimum, participant's ability to establish/maintain personal support systems or relationships and participant's ability to develop leisure, recreational, or social interests.(7-1-06)T

06. Family Status. Family status which includes, at a minimum, the participant's ability or desire to carry out family roles, participant's perception of the support he receives from his family, and the role the family plays in the participant's mental illness. For children this area addresses the child's functioning within the family and the impact of the child's mental illness on family functioning. (7-1-06)T

07. Basic Living Skills. Basic living skills which include at a minimum, participant's ability to meet age appropriate basic living skills including transition to adulthood. (7-1-06)T

08. Housing. Housing which includes at a minimum, current living situation and level of satisfaction with the arrangement, and appropriateness of current living situation with respect to the participant's needs, his health and safety. (7-1-06)T

09. Community and Legal Status. Community and Legal status which includes at a minimum, legal history with law enforcement, transportation needs, supports the participant has in the community, and daily living skills necessary for community living. (7-1-06)T

~~***10. Health or Medical Issues****. Health or medical issues, or both, including medical complications that result from the mental illness.* *(7-1-06)T*~~

114. ENHANCED *OUTPATIENT* MENTAL HEALTH SERVICES - WRITTEN INDIVIDUALIZED TREATMENT PLAN.

A written individualized treatment plan must be developed and implemented for each participant of Enhanced Mental *Outpatient* Health Services as a means to address the enhanced service needs of the participant. Each Individualized Treatment Plan must specify the amount, frequency and expected duration of treatment. ~~*(7-1-06)T*~~(7-1-06)T.

01. Goals. Services identified on the treatment plan must support the goals of any of the following as applicable to the participant's identified needs: (7-1-06)T

a. PSR. The goal is the maximum reduction of mental disability and achievement of the highest possible functioning level of that participant; for adults this means becoming independent or maintaining the highest level of independence; for children this means learning or maintaining developmentally appropriate role functioning. (7-1-06)T

b. Partial care. The goal is to decrease the severity and acuity of presenting symptoms so that the participant may be maintained in the least restrictive setting and to increase the participant's interpersonal skills in order to obtain the optimal level of interpersonal adjustment. (7-1-06)T

c. Psychotherapy. The goal is to develop and implement psychotherapeutic strategies for problem resolution. (7-1-06)T

02. Plan Content. An individualized treatment plan must include the following, at a minimum: (7-1-06)T

a. An issue statement specifically describing the participant's behavior that directly relates to his mental illness and functional impairment; (7-1-06)T

b. A statement which identifies the participant's goal relative to the goals of Enhanced *Outpatient* Mental Health Services as per Sections 120 of these rules; ~~*(7-1-06)T*~~(7-1-06)T

c. Overall goals and concrete, measurable objectives to be achieved, including time frames for completion. At least one (1) objective is required for the focus areas which must likely lead to the greatest stabilizing impact. At a minimum, this should include at least one (1) objective in each of the two (2) focus areas which qualify the participant for Enhanced *Outpatient* Mental Health Services; ~~*(7-1-06)T*~~(7-1-06)T

d. Tasks that are specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan and are developed by the participant and the selected provider(s). Each task description must specify the anticipated place of service, the frequency of services, the type of service, and the person(s) responsible to assist the participant in the completion of tasks; and (7-1-06)T

e. Documentation of who participated in the development of the individualized treatment plan. The participant, if possible, must take part in the development of the individualized treatment plan. The adult participant or the adult participant's legal guardian must sign the individualized treatment plan or documentation must be provided why this was not possible, including participant refusal to sign. For a minor child participant, the child's parent or legal guardian must sign the plan. A copy of the plan must be given to the adult participant and his legal guardian or to the parent or legal guardian when the participant is a minor child. (7-1-06)T

03. Plan Timeframes. An individualized treatment plan must be developed *and signed by a physician or a licensed practitioner of the healing arts* within thirty (30) calendar

days from initial ~~face-to-face~~ contact ~~between the provider agency staff and the participant, or the parent or legal guardian when the participant is a minor child~~. ~~(7-1-06)T~~(7-1-06)T

04. Annual Review. An individualized treatment plan review by the provider agency staff and the participant must occur at least annually. During the review, the provider agency staff and the participant review any objectives which may be added to or deleted from the individualized treatment plan. Input from other participants in the plan including service provider(s) must be considered. Other attendees of the individualized treatment plan review may be chosen by the adult participant or his legal guardian if any or, when the participant is a minor child, by his family or legal guardian and the provider agency staff. (7-1-06)T

05. Physician Review. Each individualized treatment plan must be reviewed and signed by a physician or a licensed practitioner of the healing arts at least annually. Treatment plans developed by a Mental Health Clinic must be signed by a Medical Doctor (MD) or Doctor of Osteopathy (DO). (7-1-06)T

06. Date of Plan. ~~Once~~ *Following the completion of the comprehensive assessment and* the date ~~of a~~ *the* plan is established, that date continues to be the annual date of the plan. ~~Any subsequent PSR treatment plans must be received by the Department or its designee on or before the expiration date of the current plan. If a subsequent plan is not received on or before the expiration date of the current plan, services that are provided in the interim will not be reimbursed.~~ *Mental health clinics and PSR provider agencies serving the same participant must coordinate services such that the annual review date occurs on the same anniversary date.* ~~(7-1-06)T~~(7-1-06)T

07. Choice of Providers. The eligible participant will be allowed to choose whether or not he desires to receive Enhanced *Outpatient* Mental Health Services and who the provider(s) of services will be to assist him in accomplishing the objectives stated in his individualized treatment plan. Documentation must be included in the participant's ~~file~~ *medical record* showing that the participant has been informed of his rights to refuse services and choose providers. ~~(7-1-06)T~~(7-1-06)T

08. Authorization Time Period. *PSR* Service authorizations are limited to a twelve (12) month period and must be reviewed and updated at least annually. ~~(7-1-06)T~~(7-1-06)T

09. No Duplication of Services. The ~~Department~~ *provider agency* or its designee must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to Enhanced *Outpatient* Mental Health Services participants through other Medicaid reimbursable and non-Medicaid programs. ~~(7-1-06)T~~(7-1-06)T

115. ENHANCED *OUTPATIENT* MENTAL HEALTH SERVICES - MENTAL HEALTH CLINICS (MHC).

All rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections ~~710~~ *707* through ~~717~~ *718* ~~applies~~ *apply* to Mental Health Clinic services in this chapter with the following enhancements. ~~(7-1-06)T~~(7-1-06)T

01. Psychotherapy. Under the Medicaid Enhanced Plan, individual, family and group psychotherapy services are limited to forty-five (45) hours per calendar year. (7-1-06)T

02. Partial Care Services. Under the Medicaid Enhanced Plan, partial care services are limited to thirty-six (36) hours per week per eligible participant. (7-1-06)T

a. In order to be considered a Partial Care service, the service must: (7-1-06)T

i. Be provided in a structured environment within the MHC setting; (7-1-06)T

ii. Be a needed service as indicated through the comprehensive assessment in Section 113 of these rules and Section 114 of these rules on the individualized treatment plan with documented, concrete, and measurable goals and outcomes; and (7-1-06)T

iii. Provide interventions for relieving symptoms and acquiring specific skills. These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives. (7-1-06)T

b. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection ~~*714.07*~~ *715.01*.
~~*(7-1-06)T*~~(7-1-06)T

c. Excluded Services. Services that focus on vocation, recreation or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. (7-1-06)T

116. - 119. (RESERVED).

120. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR).
Under 42 CFR 440.130(d) and in accordance with Section 39-3124, Idaho Code, the Department in each region will cover psychosocial rehabilitative services (PSR) for maximum reduction of mental disability. For PSR provided by a school district under an individualized education plan (IEP), refer to IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 850. (7-1-06)T

121. -- 122. (RESERVED).

123. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - DESCRIPTIONS.
The goal of PSR services is to aid participants in work, school, family, community, or other issues related to their mental illness. It is also to aid them in obtaining developmentally appropriate skills for living independently and to prevent movement to a more restrictive living situation. All services provided must be clinically appropriate in content, service location and duration and based on measurable and behaviorally specific and achievable objectives. ~~*In order to prevent duplication, PSR services must be coordinated with all other services received by the participant.*~~ PSR consists of the following services described in Subsections 123.01 through 123.08.
~~*(7-1-06)T*~~(7-1-06)T

01. Pharmacological Management. Pharmacological management services must be provided in accordance with the individualized treatment plan. Pharmacological management, alone, may be provided if the plan indicates that this service is necessary and sufficient to prevent

relapse or hospitalization and that functional deficits are either manageable by the participant or absent but expected to return if pharmacological management is not provided. The telephoning of prescriptions to the pharmacy is not a billable service. Medication prescription must be done by a licensed physician or other practitioner of the healing arts within the scope of practice defined in their license in visual contact with the participant. (7-1-06)T

02. Individual Psychosocial Rehabilitation (PSR). Individual psychosocial rehabilitation must be provided in accordance with the objectives specified in the individualized treatment plan. Individual PSR is a service provided to an individual participant on a one-to-one basis. Individual PSR is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications, in accordance with Section 131 of these rules. Individual PSR includes one (1) or more of the following: (7-1-06)T

a. Assistance in gaining and utilizing skills necessary to undertake school, employment, or independence. This includes helping the participant learn personal hygiene and grooming, selecting and acquiring appropriate clothing, time management and other skills related to participant's psychosocial circumstances; (7-1-06)T

b. Ongoing on-site assessment, evaluation, and feedback sessions, including one hundred twenty (120) day reviews, to identify symptoms or behaviors related to the participant's mental illness and to develop interventions with the participant and his employer or teacher; (7-1-06)T

c. Individual interventions in social skill training to improve communication skills and facilitate appropriate interpersonal behavior directly related to the participant's mental illness; (7-1-06)T

d. Problem solving, support, and supervision related to activities of daily living to assist participants in gaining and utilizing skills such as personal hygiene, household tasks, use of transportation, and money management; (7-1-06)T

e. Assisting the participant with receiving necessary services when he has difficulty or is unable to obtain them. (7-1-06)T

i. This assistance may be given by accompanying him to Medicaid-reimbursable appointments. For reimbursement purposes, the PSR agency staff person must be present during the appointment and deliver a PSR service during the appointment. Travel time and time waiting to meet with the Medicaid provider are not reimbursable; however, reimbursement is available for the delivery of prior authorized PSR services occurring during these times. (7-1-06)T

ii. To be eligible for this service, the participant must have a functional impairment that affects his ability to communicate accurately due to a mental illness and be unable to report symptoms to a licensed practitioner, as identified in Subsection 131.01 of these rules, or be unable to understand the practitioner's instructions. The impairment must be identified in the assessment. The individualized treatment plan must identify how the impairment is to be resolved and include objectives toward independence in this area. For children, this service is not intended to replace the parent's responsibility in advocating for or attending appointments for their child; (7-1-06)T

f. Medication education may be provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating the participant about the role and effects of medications in treating symptoms of mental illness and symptom management. (7-1-06)T

g. Development of coping skills and symptom management to identify the symptoms of mental illness that are barriers to successful community integration and crisis prevention. (7-1-06)T

h. May assist participant with "self" administration of medications by verbal prompts according to the direction of the prescribing physician. Verbal prompts must be delivered face-to-face and an assessment of the participant's functioning must be completed and documented. In cases where verbal prompts by phone are justified, they must be specifically prior authorized. (7-1-06)T

03. Group Psychosocial Rehabilitation (PSR). Group PSR must be provided in accordance with the objectives specified in the individualized treatment plan. Group PSR is a service provided to two (2) or more individuals concurrently. Group PSR is reimbursable if provided by an agency with a current provider agreement and the agency staff person delivering the service meets the qualifications in accordance with Section 131 of these rules. This service includes one (1) or more of the following: (7-1-06)T

a. Medication education groups provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating participants about the role and effects of medications in treating symptoms of mental illness and symptom management. These groups must not be used solely for the purpose of group prescription writing; (7-1-06)T

b. 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; (7-1-06)T

c. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior; (7-1-06)T

d. Symptom management groups to identify mental illness symptoms which 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 (7-1-06)T

e. Activities of daily living groups which help participants learn skills related to personal hygiene, grooming, household tasks, use of transportation, socialization, and money management. (7-1-06)T

04. Crisis Intervention Service. Crisis support that includes intervention for a participant in crisis situations to ensure his health and safety or to prevent his hospitalization or incarceration. Crisis intervention service is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications under

Section 131 of these rules. A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies. PSR agency staff may deliver direct services within the scope of these rules or link the participant to community resources to resolve the crisis or both. Crisis support may be provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service and the individualized treatment is either authorized the next business day following the beginning of the crisis or prior authorized in anticipation of the need for crisis support. Crisis hours are authorized on a per incident basis. (7-1-06)T

a. Crisis Support in a Community. Limitations to reimbursement in this place of service are described in Subsection 124 of these rules. (7-1-06)T

b. Crisis Support in an Emergency Department. (7-1-06)T

i. A service provided in a hospital emergency department as an adjunct to the medical evaluation completed by the emergency department physician. This evaluation may include a psychiatric assessment. (7-1-06)T

ii. The goal of this service is to assist in the identification of the least restrictive setting appropriate to the needs of the participant. (7-1-06)T

05. Collateral Contact. ~~*Collateral contacts are contacts made with significant individuals in the participant's environment for the purpose of assisting the participant to live in the community. Collateral contacts may include a parent, legal guardian, relatives, family members, landlords, employers, teachers, providers or other individuals with a primary relationship to the participant. The purpose of collateral contacts is to gather and exchange information with individuals specifically identified in the individualized treatment plan. Collateral contacts must be prior authorized. Collateral contact is reimbursable if provided by an agency with a current provider agreement and the agency staff making the contacts meet the qualifications under Section 131 of these rules. Subsection 125.06 of these rules describes limitations on reimbursement for collateral contacts between provider agency staff. The types of collateral contact are as follows:*~~ *Collateral contact is covered by Medicaid if it is included on the individualized treatment plan and is necessary to gather and exchange information with individuals having a primary relationship to the participant.* ~~*(7-1-06)T*~~(7-1-06)T

a. Collateral contact face-to-face. When two (2) persons meet ~~*visually*~~ *in person* at the same time; ~~*(7-1-06)T*~~(7-1-06)T

b. Collateral contact telephone. When it is the most expeditious and effective way to exchange information; and (7-1-06)T

c. Collateral contact parent group. When two (2) or more parents ~~*of*~~ *whose* children~~,~~ *are* under the age of eighteen (18), ~~*with*~~ *and have* similar serious emotional disturbances, meet to share information and learn about their children's needs. ~~*(7-1-06)T*~~(7-1-06)T

06. Nursing Service. A service performed by licensed and qualified nursing personnel within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code. This may include

supervision, monitoring, and administration of medications. (7-1-06)T

07. Psychotherapy. Individual, group and family psychotherapy must be prior authorized and provided in accordance with the objectives specified in the written individualized treatment plan. Staff qualified to deliver psychotherapy and qualified supervisors of psychotherapy are identified in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections ~~*710*~~ *707* through ~~*717*~~ *718*. Family psychotherapy must include the participant and at least one (1) family member ~~*at any given time*~~ and must be delivered in accordance with ~~*objectives*~~ *the goals of treatment* as specified in the written individualized treatment plan. ~~*An agency must assure clinical supervision is available to all staff that provide psychotherapy. The amount of supervision should be adequate to insure that the individualized treatment plan objectives are achieved. Documentation of supervision must be maintained by the agency and be available for review by the Department.* *(7-1-06)T*~~(7-1-06)T

08. Occupational Therapy. Occupational therapy services must be prior authorized by the Department, based on the results of an occupational therapy evaluation completed by a licensed Occupational Therapist in accordance with Subsections 131.12 and 140.08 of these rules. (7-1-06)T

124. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - COVERAGE AND LIMITATIONS.
The following service limitations apply to PSR services, unless otherwise authorized by the Department in each region. (7-1-06)T

01. Assessment~~***and Individualized Treatment Plan Development***~~. Any combination of evaluations or diagnostic services is limited to a maximum of six (6) hours annually. ~~*Additional hours may be approved by the Department under the following situations:* *(7-1-06)T*~~(7-1-06)T

~~***a.*** *When the participant selects more than one (1) provider.* *(7-1-06)T*~~

~~***b.*** *When individualized treatment plan development is being done by an agency that did not do the assessment.* *(7-1-06)T*~~

02. Individualized Treatment Plan*. Two (2) hours per year per participant per provider agency are available for treatment plan development.* *(7-1-06)T*

0~~*2*~~3. Psychotherapy. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. (7-1-06)T

0~~*3*~~4. Crisis Intervention Service. A maximum of twenty (20) hours of crisis support in a community may be reimbursed per crisis during any consecutive five (5) day period. Authorization must follow procedure described above at Subsection 123.06 of these rules. (7-1-06)T

0~~*4*~~5. Psychosocial Rehabilitation. ~~*Individual and group*~~ *Any combination of* PSR services *excluding crisis hours* are not to exceed twenty (20) hours per week and must ~~*receive*~~ *be* prior ~~*authorization from*~~ *authorized by* the Department. Services in excess of twenty (20) hours require additional review and prior authorization~~*by the Department in each region*~~. ~~*The prior*~~

~~authorization of additional hours must be documented in the individualized treatment plan and written approval must be retained in the participant's file. (7-1-06)T~~(7-1-06)T

0~~5~~6. Place of Service. PSR services are to be home and community-based. (7-1-06)T

a. PSR services must be provided to the participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the individualized treatment plan and is prior authorized. (7-1-06)T

b. PSR services may be provided to a participant living in a residential or assisted living facility if the PSR services are determined by the Department to be appropriate, desired by the resident, and are not the responsibility of the facility or another agency under the Negotiated Service Agreement for residential or assisted living facilities. (7-1-06)T

c. *Prior to delivering any services in a school-based setting, the PSR agency must have a contract with the school or the Infant Toddler program. The PSR agency must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856. (7-1-06)T*

125. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID.
Excluded services are those services that are not reimbursable under Medicaid PSR. The following is a list of those services: (7-1-06)T

01. Inpatient. Treatment services rendered to participants residing in inpatient medical facilities including nursing homes, or hospitals, except those identified in Subsection 140.09 of these rules. (7-1-06)T

02. Recreational and Social Activities. Activities which are primarily social or recreational in purpose. (7-1-06)T

03. Employment. Job-specific interventions, job training and job placement services which includes helping the participant develop a resume, applying for a job, and job training or coaching. (7-1-06)T

04. Household Tasks. Staff performance of household tasks and chores. (7-1-06)T

05. Treatment of Other Individuals. Treatment services for persons other than the identified participant. (7-1-06)T

06. Participant Staffing Within an Agency. A participant staffing between two (2) staff who both provide PSR services within the same agency is not reimbursable. A participant staffing may fall under the definition of collateral contact when it is prior authorized and occurs between two (2) staff who are providing services from different Medicaid programs either within or outside the same agency. (7-1-06)T

07. Medication Drops. Delivery of medication only; (7-1-06)T

08. Services Delivered on an Expired Individualized Treatment Plan. Services provided between the expiration date of one (1) plan and the start date of the subsequent treatment plan. (7-1-06)T

09. Transportation. The provision of transportation services and staff time to transport. (7-1-06)T

10. Inmate of a Public Institution. Treatment services rendered to participants who are residing in a public institution as defined in 42 CFR 435.1009. (7-1-06)T

11. Services Not Listed. Any other services not listed in Section 123 of these rules. (7-1-06)T

126. -- 127. (RESERVED).

128. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - RESPONSIBILITIES OF THE DEPARTMENT.
The Department will administer the provider agreement for the provision of PSR services and is responsible for the following tasks: (7-1-06)T

01. Credentialing. The Department is responsible for ensuring Medicaid PSR agencies meet credentialing requirements *described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712*. ~~*(5-1-06)T*~~(5-1-06)T

~~***02. Assessment Authorization**. The Department will review requests for assessment hours and authorize as appropriate.* *(7-1-06)T*~~

0~~3~~2. Individualized Treatment Plan ~~*Authorization*~~ Requirements. Individualized treatment plan*s* ~~*authorizations*~~ must include the following: ~~*(7-1-06)T*~~(7-1-06)T

a. Required Documentation. The required documentation for each individualized treatment plan includes: (7-1-06)T

i. Participant demographic information; (7-1-06)T

ii. A comprehensive assessment as provided in Subsection 123.01 of these rules; ~~*and*~~ ~~*(7-1-06)T*~~(7-1-06)T

iii. A written individualized treatment plan as provided in Section 126 of these rules~~.~~; ~~*(7-1-06)T*~~(7-1-06)T

iv. Adult ~~*service*~~ *treatment* plans ~~*also*~~ require a ~~*rehabilitation outcome database.*~~ *mental health client profile; and* ~~*(7-1-06)T*~~(7-1-06)T

v. Children's individualized treatment plans also require the Child and Adolescent

Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). (7-1-06)T

b. ~~*Physician's Signature and*~~ Receipt of Required Documentation. Reimbursement for services will be authorized from the date ~~*of the physician's signature if the required documentation is received by the Department within thirty (30) days from the request of assessment hours. If the documentation is received after thirty (30) days from the date of the request of assessment hours, or after the expiration of the plan, the date to begin services is the date*~~ the individualized treatment plan and other required documentation are received by the Department. For the annual update, all required documentation must be received by the Department before the expiration date of the current assessment and plan. In order for a prior authorization to remain valid throughout the treatment plan year, documentation of the one hundred twenty (120) day reviews must comply with Subsection 136.05 of these rules.
~~*(7-1-06)T*~~(7-1-06)T

c. Hours and Type of Service. The Department must authorize the number of hours and type of services which could be reasonably expected to lead to achievement of the individualized treatment plan objectives. (7-1-06)T

d. Authorization Time Period. Service authorizations are limited to a twelve (12) month period and must be reviewed and updated at least annually. (7-1-06)T

~~*e. No Duplication of Services. The Department must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to PSR participants through other Medicaid reimbursable and non-Medicaid programs. (7-1-06)T*~~

0~~*4*~~*3*. Notice of Decision. At the point *the Department makes* a decision ~~*is made*~~ that a participant is ineligible for PSR services, a notice of decision citing the reason(s) the participant is ineligible for PSR services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian.
~~*(7-1-06)T*~~(7-1-06)T

0~~*5*~~*4*. ~~*Changes*~~ *Increases* in Individualized Treatment Plan Hours or *Change in* Service Type. When the Department is notified, in writing, by the provider of recommended increases in hours or change in type of service provided, the Department must review the request and either approve or deny *the request* within ten (10) working days of receipt. A clear rationale for the ~~*change*~~ *increase* in hours or *change in* service type must be included with the request.
~~*(7-1-06)T*~~(7-1-06)T

0~~*6*~~*5*. Changes to Individualized Treatment Plan Objectives *or Tasks*. When a provider believes that an individualized treatment plan needs to be revised *without increasing hours or changing type of service*, the provider should ~~*include that recommendation and rationale in documentation*~~ *amend the individualized treatment plan at the time* of the next one hundred twenty-day (120) review~~*. The Department will review the information, and if appropriate, act on the recommendation. In the event*~~ *or when* substantial changes in the participant's mental status or circumstances ~~*occur requiring*~~ *require* immediate changes in the plan objectives~~*, the provider must notify the Department, in writing, of its recommendation and rationale for the change. The*~~

~~Department has ten (10) working days to respond to and either approve or deny the request for change~~. The amended individualized treatment plan must be retained in the participant's record and submitted to the Department upon request. ~~(7-1-06)T~~(7-1-06)T

06. Service System. The Department is responsible for the development, maintenance and coordination of regional, comprehensive and integrated service systems. (7-1-06)T

~~**07. Minor Changes to Individualized Treatment Plan Tasks**. When the Department is notified in writing by the provider of necessary and specific changes to individualized treatment plan tasks that require no change in total hours or service type, a copy of the amended individualized treatment plan tasks must be forwarded to the Department including rationale for those changes. The Department has ten (10) working days to respond to the changes. If no response is received, the provider may proceed to incorporate those and only those specific task changes into the individualized treatment plan. While task changes may result in reassignment of available hours among tasks, under no circumstances does this permit the provider to increase the total number of prior authorized hours. (7-1-06)T~~

~~**08. Quality of Services**. The Department must monitor the quality and outcomes of PSR services provided to participants, in coordination with the Divisions of Medicaid, Management Services, and Family and Community Services. (7-1-06)T~~

129. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - PROVIDER RESPONSIBILITIES

01. Provider Agreement. Each provider must enter into a provider agreement with the Division of Medicaid for the provision of PSR services and also is responsible for the following tasks: (7-1-06)T

02. Service Provision. Each provider must have signed additional terms to the general provider agreement with the Department. (7-1-06)T

03. Service Availability. Each provider must assure provision of PSR services to participants on a twenty-four (24) hour basis. (7-1-06)T

04. Comprehensive Assessment and Individualized Treatment Plan Development. The provider agency is responsible to conduct a comprehensive assessment and develop an individualized treatment plan for each participant if these services have not already been completed by another provider. In the event the agency makes a determination that it cannot serve the participant, the agency must make appropriate referrals to other agencies to meet the participant's identified needs. (7-1-06)T

05. Individualized Treatment Plan. The provider must develop an individualized treatment plan in accordance with Section 114 of these rules. The signature of a physician, or other licensed practitioner of the healing arts within the scope of his practice under state law is required on the individualized treatment plan indicating the services are medically necessary. The date of the *initial* plan is the date it is signed by the physician ~~if all the required documentation is received by the Department within thirty (30) days of the date of the request for assessment hours~~. Reimbursement for services will be authorized according to Subsection 128.02.b. of these rules.

~~(7-1-06)T~~(7-1-06)T

06. Changes to Individualized Treatment Plan Objectives. When a provider believes that an individualized treatment plan needs to be revised, the provider should include that recommendation and rationale in the documentation for the next one hundred twenty (120) day review. (7-1-06)T

07. Effectiveness of Services. Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the individualized treatment plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included on the participant's one hundred twenty (120) day review. (7-1-06)T

08. Healthy Connections Referral~~—*Number*~~. Providers must obtain a Healthy Connections referral ~~*number*~~ if the participant is enrolled in the Healthy Connections program. ~~(7-1-06)T~~(7-1-06)T

130. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - PROVIDER AGENCY REQUIREMENTS.
Each agency that enters into a provider agreement with the Department for the provision of PSR services must meet the following requirements: (7-1-06)T

01. Agency. A PSR agency must be a proprietorship, partnership, corporation, or other entity, employing at least two (2) staff qualified to deliver PSR services under Section 131 of these rules, and offering both PSR services and administrative services. Administrative services may include such activities as billing, hiring staff, assuring staff qualifications are met and maintained, setting policy and procedure, payroll. (7-1-06)T

02. Criminal History Checks. (7-1-06)T

a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or PSR services have complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." (7-1-06)T

b. Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check. (7-1-06)T

c. Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction. (7-1-06)T

03. PSR Agency Staff Qualifications. The agency must assure that each agency staff person delivering PSR services meets at least one (1) of the qualifications in Section 131 of these rules. (7-1-06)T

04. Additional Terms. The agency must have signed additional terms to the general provider agreement with the Department. The additional terms must specify what PSR services

must be provided by the agency. The agency's additional terms may be revised or cancelled at any time. (7-1-06)T

05. Agency Employees and Subcontractors. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (7-1-06)T

06. Supervision. The agency must provide staff with adequate supervision to insure that the tasks on a participant's individualized treatment plan can be implemented effectively in order for the individualized treatment plan objectives to be achieved. *Individuals in Subsections 131.09 through 131.12 of these rules must be supervised by individuals in Subsections 131.01 through 131.07 of these rules.* (7-1-06)T

a. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement. ~~*Individuals in Subsections 131.09 through 131.12 of these rules must be supervised by individuals in Subsections 131.01 through 131.08 of these rules.*~~ Documentation of supervision must be maintained by the agency and be available for review by the Department. ~~*(7-1-06)T*~~(7-1-06)T

b. *An agency must assure clinical supervision is available to all staff that provide psychotherapy. The amount of supervision should be adequate to ensure that the individualized treatment plan objectives are achieved. Documentation of supervision must be maintained by the agency and be available for review by the Department.* *(7-1-06)T*

07. Continuing Education. The agency must assure that all staff complete twenty (20) hours of continuing education annually from the date of hire. Four (4) hours every four (4) years must be in ethics training. Staff who are not licensed must select the discipline closest to their own and use the continuing education standards attached to that professional license. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (7-1-06)T

08. Crisis Service Availability. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services. (7-1-06)T

09. Building Standards, Credentialing and Ethics. PSR Agencies must follow the rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section*s* ~~*715*~~ *712 and 714*. ~~*(7-1-06)T*~~(7-1-06)T

131. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - AGENCY STAFF QUALIFICATIONS.

All agency staff delivering PSR services must meet at least one (1) of the following qualifications: (7-1-06)T

01. Licensed Physician or Psychiatrist. A physician, psychiatrist, or other licensed practitioners of the healing arts within the scope of his practice under state law must be licensed in accordance with Title 54, Chapter 18, Idaho Code, to practice medicine. A licensed practitioner of the healing arts in Idaho may include Physician Assistants and Nurse Practitioners. (7-1-06)T

02. Licensed Master's Level Psychiatric Nurse. A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (7-1-06)T

03. Licensed Psychologist. A psychologist must be licensed in accordance with Title 54, Chapter 23, Idaho Code. (7-1-06)T

04. Licensed Clinical Professional Counselor or Licensed Professional Counselor. A clinical professional counselor or professional counselor must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-06)T

05. Licensed Marriage and Family Therapist. A marriage and family therapist must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-06)T

06. Licensed Masters Social Worker or Licensed Clinical Social Worker. A masters social worker (LMSW) or clinical social worker (LCSW), must hold a license in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (7-1-06)T

07. Clinician. A clinician must hold a master's degree, be employed by a state agency and meet the minimum standards established by the Idaho State Division of Human Resources and the Idaho Department of Health and Welfare Division of Human Resources. (7-1-06)T

08. Licensed Social Worker. A social worker must hold a license in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (7-1-06)T

09. Licensed Professional Nurse (RN). A licensed professional nurse or RN, must be licensed in accordance with Title 54, Chapter 14, Idaho Code. (7-1-06)T

10. Psychosocial Rehabilitation (PSR) Specialist. A PSR specialist must hold at least a bachelor's degree from a nationally accredited university or college in behavioral science education, or medicine. A PSR specialist must have at least twenty-one (21) semester credit hours (or quarter hour equivalent) in human service fields such as psychology, social work, special education, counseling, and psychosocial rehabilitation. An individual who has been denied licensure, or who is qualified to apply for licensure to the State of Idaho, Bureau of Occupational Licenses in the professions identified in Subsections 131.01 through 131.10 of this rule, is not eligible to provide services under the designation of Psychosocial Rehabilitation Specialist. Individuals approved as PSR specialists under previous rules in this section will be able to continue as qualified PSR specialists as long as they continue to work in the same agency as they did prior to the effective date of this rule. (7-1-06)T

11. Licensed Occupational Therapist. An occupational therapist must be licensed in

accordance with Title 54, Chapter 37, Idaho Code, and IDAPA 22.01.09, "Rules for the Licensing of Occupational Therapists and Occupational Therapist Assistants." Training and experience in a mental health setting are required. (7-1-06)T

12. Psychologist Extender. A psychologist extender must work under the supervision of a licensed psychologist and be registered with the Bureau of Occupational Licenses. A copy of that registration must be retained in the extender's personnel file. (7-1-06)T

132. -- 135. (RESERVED).

136. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - RECORD REQUIREMENTS FOR PROVIDERS.
In addition to the development and maintenance of the individualized treatment plan, the following documentation must be maintained by the provider of PSR services: (7-1-06)T

01. Name. Name of participant. (7-1-06)T

02. Provider. Name of the provider agency and the agency staff person delivering the service. (7-1-06)T

03. Date, Time, Duration of Service, and Justification. Documentation of the date, time, and duration of service, and the justification for the length of time which is billed must be included in the record. (7-1-06)T

04. Documentation of Progress. The written description of the service provided, the place of service, and the response of the participant must be included in the progress note. A separate progress note is required for each contact with a participant. (7-1-06)T

05. One Hundred Twenty Day Review. A documented review of progress toward each individualized treatment plan goal and objective must be kept in the participant's file. (7-1-06)T

a. A copy of the review must be sent to the Department upon request. Failure to do so may result in the loss of a prior authorization or result in a recoupment of reimbursement provided for services delivered after the one hundred twenty (120) day review due date. (7-1-06)T

b. The review must also include a reassessment of the participant's continued need for services. The review must occur at least every one hundred twenty (120) days and be conducted in visual contact with the participant. For children, the review must include a new CAFAS/PECFAS for the purpose of measuring functional impairment. (7-1-06)T

c. After eligibility has been determined, subsequent CAFAS/PECFAS scores are used to measure progress and functional impairment and should not be used to terminate services. (7-1-06)T

06. Signature of Staff Delivering Service. The legible, dated signature, with degree credentials listed, of the staff person delivering the service. (7-1-06)T

07. Choice of Provider. Documentation of the participant's choice of provider must be maintained in the participant's file prior to the implementation of the individualized treatment plan. (7-1-06)T

08. Closure of Services. A discharge summary must be included in the participant's record and submitted to the Department identifying the date of closure, reason for ending services, progress on objectives, and referrals to supports and other services. (7-1-06)T

09. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. For services paid at the fifteen (15) minute incremental rate, providers will not be reimbursed for more than one (1) contact during a single fifteen (15) minute time period. (7-1-06)T

137. - 139. (RESERVED).

140. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - ~~*PAYMENT METHODOLOGY*~~ *PROVIDER REIMBURSEMENT*.
Payment for PSR services must be in accordance with rates established by the Department. The rate paid for services includes documentation. (7-1-06)T

01. Duplication. Payment for services must not duplicate payment made to public or private entities under other program authorities for the same purpose. (7-1-06)T

02. Number of Staff Able to Bill. Only one (1) staff member may bill for an assessment, individualized treatment plan, or case review when multiple PSR staff are present. (7-1-06)T

03. Medication Prescription and Administration. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18, Idaho Code. (7-1-06)T

04. Recoupment. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules must be cause for recoupment of payments for services, sanctions, or both. (7-1-06)T

05. Access to Information. Upon request, the provider must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request must result in termination of the Medicaid PSR Provider Agreement. (7-1-06)T

06. Evaluations and Tests. Evaluations and tests may be provided as a reimbursable service in conjunction with the assessment. (7-1-06)T

07. Psychological Evaluations. Psychological evaluations are reimbursable if provided in accordance with the requirements in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections ~~*710*~~ *707* through ~~*717*~~ *718*. ~~*(7-1-06)T*~~(7-1-06)T

08. Evaluations by Occupational Therapists. Evaluations performed by qualified licensed occupational therapists, performed in conjunction with development of an individualized treatment plan are reimbursable. (7-1-06)T

09. Psychiatric or Medical Inpatient Stays. 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 inpatient facility. Treatment services are the responsibility of the facility. (7-1-06)T

***10. Reimbursement for Services Provided in a School**. PSR Services provided by a PSR agency in a school-based setting, must be billed by the school district, charter school, or the Idaho Infant Toddler program. (7-1-06)T*

141. - 145. (RESERVED).

146. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - QUALITY OF SERVICES.
The Department must monitor the quality and outcomes of PSR services provided to participants, in coordination with the Divisions of Medicaid, Management Services, and ~~*Family and Community Services*~~ *Behavioral Health*. ~~*(7-1-06)T*~~(7-1-06)T

147. -- 199. (RESERVED).

SUB AREA: ENHANCED HOME HEALTH CARE
(Sections 200 Through 214)

200. PRIVATE DUTY NURSING SERVICES.
Private Duty Nursing services are nursing services provided by a licensed professional nurse or licensed practical nurse to a non-institutionalized child under the age of twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. Sections 200 through 209 of these rules cover requirements for private duty nursing services. (7-1-06)T

201. PRIVATE DUTY NURSING. - DEFINITIONS.
The following definitions apply to Sections 200 through Section 209 of these rules. (7-1-06)T

01. Primary RN. The RN identified by the family to be responsible for development, implementation, and maintenance of the Medical Plan of Care. (7-1-06)T

02. Private Duty Nursing (PDN) RN Supervisor. An RN providing oversight of PDN services delegated to LPN's providing the child's care, in accordance with IDAPA 23.01.01, "Rules of the Board of Nursing." (7-1-06)T

202. PRIVATE DUTY NURSING - ELIGIBILITY.
To be eligible for Private Duty Nursing (PDN), the nursing needs must be of such a nature that the Idaho Nursing Practice Act, Rules, Regulations, or policy require the service to be provided by an Idaho Licensed Professional Nurse (RN), or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from Home Health nursing services.

PDN service must be authorized by the Department prior to delivery of service. (7-1-06)T

203. PRIVATE DUTY NURSING - FACTORS ASSESSED FOR ELIGIBILITY AND REDETERMINATION.
Factors assessed for eligibility/redetermination include: (7-1-06)T

01. Age for Eligibility. The individual is under the age of twenty - one (21) years. (7-1-06)T

02. Maintained in Personal Residence. That the child is being maintained in their personal residence and receives safe and effective services through PDN services. (7-1-06)T

03. Medical Justification. The child receiving PDN services has medical justification and physician's orders. (7-1-06)T

04. Written Plan of Care. That there is an updated written plan of care signed by the attending physician, the parent or legal guardian, PDN, RN supervisor, and a representative from the Department. (7-1-06)T

05. Attending Physician. That the attending physician has determined the number of PDN hours needed to ensure the health and safety of the child in his home. (7-1-06)T

06. Redetermination. Redetermination will be at least annually. The purpose of an annual redetermination for PDN is to: (7-1-06)T

a. Determine if the child continues to meet the PDN criteria in Subsection 203.01 through 203.05 of these rules; and (7-1-06)T

b. Assure that services and care are medically necessary and appropriate. (7-1-06)T

204. PRIVATE DUTY NURSING - COVERAGE AND LIMITATIONS.
PDN services are functions which can not be delegated to an Unlicensed Assistive Personnel (UAP) as defined by Idaho Code and IDAPA 23.01.01, “Rules of the Idaho Board of Nursing.” (7-1-06)T

01. Ordered by a Physician. PDN Services must be ordered by a physician and include: (7-1-06)T

a. A medical status that is so complex or unstable, as determined by the attending physician, that licensed or professional nursing assessment is needed to determine the need for changes in medications or other interventions; or (7-1-06)T

b. An assessment by a licensed professional nurse of a child's health status for unstable chronic conditions, which includes an evaluation of the child's responses to interventions or medications. (7-1-06)T

02. Plan of Care. PDN Services must include a Plan of Care. The plan of care must: (7-1-06)T

a. Be developed by a multi-disciplinary team to include, at a minimum, the parent or legal guardian, the primary PDN, RN, or RN Supervisor, and a representative from the Department; (7-1-06)T

b. Include all aspects of the medical, licensed, and personal care services medically necessary to be performed, including the amount, type, and frequency of such service; (7-1-06)T

c. Must be approved and signed by the attending physician, parent or legal guardian, and primary PDN, RN, or RN supervisor, and a representative from the Department; and (7-1-06)T

d. Must be revised and updated as child's needs change or upon significant change of condition, but at least annually, and must be submitted to the Department for review and prior authorization of service. (7-1-06)T

03. Status Updates. Status updates must be completed every ninety (90) days from the start of services. The Status Update is intended to document any change in the child's health status. Annual plan reviews will replace the fourth quarter Status Update. The Status Update must be signed by both the parent or legal guardian and the primary RN supervisor completing the form. (7-1-06)T

04. Limitations. PDN Services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. However, if service is requested only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences: (7-1-06)T

a. Licensed Nursing Facilities (NF); (7-1-06)T

b. Licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR); (7-1-06)T

c. Residential Care or Assisted Living Facilities; (7-1-06)T

d. Licensed hospitals; and (7-1-06)T

e. Public or private school. (7-1-06)T

205. - 208. (RESERVED).

209. PRIVATE DUTY NURSING - PROVIDER QUALIFICATIONS AND DUTIES.

01. Primary RN Responsibility For PDN Redetermination. Primary RN responsibility for PDN redetermination is to submit a current plan of care to the Department at least annually or as the child's needs change. Failure to submit an updated plan of care to the Department prior to the end date of the most recent authorization will cause payments to cease until completed information is received and evaluated and authorization given for further PDN

services. The plan of care must include all requested material outlined in Subsection 204.02 of these rules. (7-1-06)T

02. Physician Responsibilities. Physician responsibilities include: (7-1-06)T

a. Medical Information. Provide the Department the necessary medical information in order to establish the child's medical eligibility for services based on an EPSDT screen. (7-1-06)T

b. Order Services. Order all services to be delivered by the private duty nurse. (7-1-06)T

c. Sign Medical Plan of Care. Review, sign, and date child's Medical Plan of Care and orders at least annually or as condition changes. (7-1-06)T

d. Community Resources. Determine if the combination of PDN Services along with other community resources are sufficient to ensure the health or safety of the child. If it is determined that the resources are not sufficient to ensure the health and safety of the child, notify the family and the Department and facilitate the admission of the child to the appropriate medical facility. (7-1-06)T

03. Private Duty Nurse Responsibilities. RN supervisor or an RN providing PDN services responsibilities include: (7-1-06)T

a. Notify the physician immediately of any significant changes in the child's medical condition or response to the service delivery; (7-1-06)T

b. Notify the Department within forty-eight (48) hours or on the first business day following a weekend or holiday of any significant changes in the child's condition or if the child is hospitalized at any time; (7-1-06)T

c. Evaluate changes of condition; (7-1-06)T

d. Provide services in accordance with the nursing care plan; and (7-1-06)T

e. Must ensure copies of records are maintained in the child's home. Records of care must include: (7-1-06)T

i. The date; (7-1-06)T

ii. Time of start and end of service delivery each day; (7-1-06)T

iii. Comments on child's response to services delivered; (7-1-06)T

iv. Nursing assessment of child's status and any changes in that status per each working shift; (7-1-06)T

v. Services provided during each working shift; and (7-1-06)T

vi. The Medical Plan of Care signed by the physician, primary RN, the parent or legal guardian and a representative from the Department. (7-1-06)T

04. LPN Providers. In the case of LPN providers, document that oversight of services by an RN is in accordance with the Idaho Nursing Practice Act and IDAPA 23.01.01, "Rules of the Board of Nursing." RN Supervisor visits must occur at least once every thirty (30) days when services are provided by an LPN. (7-1-06)T

05. Ensure Health and Safety of Children. PDN providers must notify the physician if the combination of Private Duty Nursing Services along with other community resources are not sufficient to ensure the health or safety of the child. (7-1-06)T

210. - 214. (RESERVED).

SUB AREA: THERAPIES
(Sections 215 Through 219)

215. PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY SERVICES.
In addition to the providers listed at IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 730 through 738, physical, speech, and occupational therapy services are covered under these rules when provided by a Developmental Disabilities Agencies. (7-1-06)T

216. - 219. (RESERVED).

SUB AREA: LONG-TERM CARE
(Sections 220 Through 299)

220. NURSING FACILITY.
The Enhanced Plan Benefit includes nursing facilities services permitted under Section 1905(a)(4)(A) of the Social Security Act. These services include nursing facilities services (other than services in an institution for mental diseases) for individuals determined to be in need of such care. (7-1-06)T

221. (RESERVED).

222. NURSING FACILITY SERVICES - ELIGIBILITY.
Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Regional Nurse Reviewer (RNR) has determined that the individual meets the criteria for nursing facility services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. (7-1-06)T

01. Criteria for Determination. The criteria for determining a medical assistance participant's need for nursing facility care is described in Section 223. In addition, the Inspection of Care/Utilization Control (IOC/UC) nurse must determine whether a medical assistance participant's needs could be met by alternatives other than residing in a nursing facility, such as an independent living arrangement or residing in a room and board situation. (7-1-06)T

a. The participant can select any certified facility to provide the care required . (7-1-06)T

b. The final decision as to the level of care required by a medical assistance participant must be made by the IOC/UC Nurse. (7-1-06)T

c. The final decision as to the need for developmental disability (DD) or mental illness (MI) active treatment must be made by the appropriate Department staff as a result of the Level II screening process. (7-1-06)T

d. No payment will be made by the Department on behalf of any eligible medical assistance participant to any long-term care facility which, in the judgment of the IOC/UC Team, is admitting individuals for care or services which are beyond the facility's licensed level of care or capability. (7-1-06)T

02. Authorization of Long-Term Care Payment. If it has been determined that a person eligible for medical assistance is entitled to medical assistance participation in the cost of long-term care, and that the facility selected by the participant is licensed and certified to provide the level of care the participant requires, the Field Office will forward to such facility an "Authorization for Long-Term Care Payment" form HW 0459. (7-1-06)T

223. NURSING FACILITY - CRITERIA FOR DETERMINING NEED.
The participant requires nursing facility level of care when an adult meets or exceeds the functional level described in Subsection 223.06 of these rules, or when a child meets one (1) or more of the criteria described in Subsections 223.07, 223.08, 223.09 or 223.10 of these rules. A child is an individual from age zero (0) through eighteen (18) years; an adult is an individual more than eighteen (18) years. (7-1-06)T

01. Required Assessment for Adults. A standard assessment will be administered by the Department to all adults requesting services with requirements for nursing facility level of care. The Department will specify the instrument to be used. (7-1-06)T

02. Functional Level for Adults. Based on the results of the assessment, the level of impairment of the individual will be established by the Department. In determining need for nursing facility care an adult must require the level of assistance listed in Subsections 223.03 through 223.05, according to the formula described in Subsection 223.06: (7-1-06)T

03. Critical Indicator - 12 Points Each. (7-1-06)T

a. Total assistance with preparing or eating meals. (7-1-06)T

b. Total or extensive assistance in toileting. (7-1-06)T

c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. (7-1-06)T

04. High Indicator - 6 Points Each. (7-1-06)T

a. Extensive assistance with preparing or eating meals. (7-1-06)T

b. Total or extensive assistance with routine medications. (7-1-06)T

c. Total, extensive or moderate assistance with transferring. (7-1-06)T

d. Total or extensive assistance with mobility. (7-1-06)T

e. Total or extensive assistance with personal hygiene. (7-1-06)T

f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). (7-1-06)T

05. Medium Indicator - 3 points each. (7-1-06)T

a. Moderate assistance with personal hygiene. (7-1-06)T

b. Moderate assistance with preparing or eating meals. (7-1-06)T

c. Moderate assistance with mobility. (7-1-06)T

d. Moderate assistance with medications. (7-1-06)T

e. Moderate assistance with toileting. (7-1-06)T

f. Total, extensive, or moderate assistance with dressing. (7-1-06)T

g. Total, extensive or moderate assistance with bathing. (7-1-06)T

h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. (7-1-06)T

06. Nursing Facility Level of Care, Adults. In order to qualify for nursing facility level of care, the individual must score twelve (12) or more points in one (1) of the following ways. (7-1-06)T

a. One (1) or more critical indicators = Twelve (12) points. (7-1-06)T

b. Two (2) or more high indicators = Twelve (12) points. (7-1-06)T

c. One (1) high and two (2) medium indicators = Twelve (12) points. (7-1-06)T

d. Four (4) or more medium indicators = Twelve (12) points. (7-1-06)T

07. Supervision Required for 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. (7-1-06)T

08. Preventing Deterioration for 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. (7-1-06)T

09. Specific Needs for 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. (7-1-06)T

10. Nursing Facility Level of Care for Children. Using the criteria found in Subsections 223.07, 223.08, and 223.09 of these rules, plus consideration of the developmental milestones, based on the age of the child, the Department's RMS will determine nursing facility level of care. (7-1-06)T

11. Conditions of Payment. (7-1-06)T

a. As a condition of payment by the Department for long-term care on behalf of medical assistance participants, each fully licensed long-term care facility is to be under the supervision of an administrator who is currently licensed under the laws of the state of Idaho and in accordance with the rules of the Bureau of Occupational Licenses. (7-1-06)T

b. Payment by the Department for the cost of long-term care is to include the date of the participant's discharge only if the discharge occurred after 3:00 p.m. (7-1-06)T

224. NURSING FACILITY - POST-ELIGIBILITY TREATMENT OF INCOME.
Where an individual is determined eligible for medical assistance participation in the cost of his long term care, the Department must reduce its payment to the long term care facility by the amount of his income considered available to meet the cost of his care. This determination is made in accordance with IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)," Sections 721 through 726. The amount which the medical assistance participant receives from SSA as reimbursement for his payment of the premium for Part B of Title XVIII (Medicare) is not considered income for patient liability under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)," Section 317. (7-1-06)T

225. NURSING FACILITY SERVICES - COVERAGE AND LIMITATIONS.
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. (7-1-06)T

01. Nursing Facility Care. The minimum content of care and services for nursing facility patients must include the following: (7-1-06)T

a. Room and board; (7-1-06)T

b. Bed and bathroom linens; (7-1-06)T

c. Nursing care, including special feeding if needed; (7-1-06)T

d. Personal services; (7-1-06)T

e. Supervision as required by the nature of the patient's illness; (7-1-06)T

f. Special diets as prescribed by a patient's physician; (7-1-06)T

g. All common medicine chest supplies which do not require a physician's prescription including but not limited to mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; (7-1-06)T

h. Dressings; (7-1-06)T

i. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (7-1-06)T

j. Application or administration of all drugs; (7-1-06)T

k. All medical supplies including but not limited to gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton or any other type of pads used to save labor or linen, and disposable gloves;(7-1-06)T

l. Social and recreational activities; and (7-1-06)T

m. Items which are utilized by individual patients but which are reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. (7-1-06)T

02. Skilled Services. Skilled services include services which could qualify as either skilled nursing or skilled rehabilitative services, which include: (7-1-06)T

a. Overall management and evaluation of the care plan. The development, management, and evaluation of a resident's care plan, based on the physician's orders, constitute skilled services when, in terms of the patient's physical or mental condition, such development, management, and evaluation necessitate the involvement of technical or professional personnel to meet his needs, promote his recovery, and assure his medical safety. This would include the management of a plan involving only a variety of personal care services where, in light of the patient's condition, the aggregate of such services necessitates the involvement of technical or professional personnel. Where the patient's overall condition would support a finding that his recovery and safety could be assured only if the total care he requires is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided. (7-1-06)T

b. Observation and assessment of the resident's changing condition. When the resident's condition is such that the skills of a licensed nurse or other technical or professional

person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until his condition is stabilized, such services constitute skilled services. (7-1-06)T

03. Direct Skilled Nursing Services. Direct skilled nursing services include the following: (7-1-06)T

a. Intravenous injections; intravenous feedings; intramuscular or subcutaneous injection required on more than one (1) shift; (7-1-06)T

b. Nasopharyngeal feedings; (7-1-06)T

c. Nasopharyngeal and tracheotomy aspiration; (7-1-06)T

d. Insertion and sterile irrigation and replacement of catheters; (7-1-06)T

e. Application of dressings involving prescription medications or aseptic techniques; (7-1-06)T

f. Treatment of extensive decubitus ulcers or other widespread skin disorders; (7-1-06)T

g. Heat treatments which have been specifically ordered by a physician as part of treatment and which require observation by nurses to adequately evaluate the resident's progress; and (7-1-06)T

h. Initial phases of a regimen involving administration of oxygen. (7-1-06)T

04. Direct Skilled Rehabilitative Services. Direct skilled rehabilitative services include the following: (7-1-06)T

a. Ongoing assessment of rehabilitation needs and potential, services concurrent with the management of a resident's care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders; (7-1-06)T

b. Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the resident, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the resident and the effectiveness of the treatment; (7-1-06)T

c. Gait evaluation and training furnished by a physical or occupational therapist to restore function in a resident whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality; and (7-1-06)T

d. Ultrasound, short-wave, and microwave therapy treatments by a licensed physical therapist. (7-1-06)T

05. Other Treatment and Modalities. Other treatment and modalities which include hot pack, hydroculator, infrared treatments, paraffin baths, and whirlpool, in cases where the resident's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgement of a licensed physical therapist are required. (7-1-06)T

226. NURSING FACILITY - PROCEDURAL RESPONSIBILITIES.

01. Nursing Facility Responsibility. Each nursing facility administrator, or his authorized representative must report the following information to the appropriate RMS within three (3) working days of the date the facility has knowledge of the following. (7-1-06)T

a. Any readmission or discharge of a participant, and any temporary absence of a participant due to hospitalization or therapeutic home visit. (7-1-06)T

b. Any changes in the amount of a participant's income. (7-1-06)T

c. When a participant's account has exceed the following amount; (7-1-06)T

i. For a single individual, one thousand eight hundred dollars ($1,800);or 7-1-06)T

ii. For a married couple, two thousand eight hundred dollars ($2,800). (7-1-06)T

02. Other Financial Information for Participant. Other information about a participant's finances which may potentially affect eligibility for medical assistance *must be reported if the nursing facility has any knowledge of the participant's financial information*.
~~*(7-1-06)T*~~(7-1-06)T

227. PREADMISSION SCREENING AND ADDITIONAL RESIDENT REVIEW PROGRAM (PASARR).
All Medicaid certified nursing facilities must participate in, cooperate with, and meet all requirements imposed by, the Preadmission Screening and Additional Resident Review program, (PASARR) as set forth in 42 CFR, Part 483, Subpart C. (7-1-06)T

01. Background and Purpose. The purpose of these provisions is to comply with and implement the PASARR requirements imposed on the state by federal law. The purpose of those requirements is to prevent the placement of individuals with mental illness (MI) or mental retardation (MR) in a nursing facility unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. This is accomplished by both pre-admission screening (PAS) and additional resident review (ARR). Individuals, for whom it appears that a diagnosis of MI or MR is likely, are identified for further screening by means of a Level I screen. The actual PASARR is accomplished through a Level II screen where it is determined whether, because of the individual's physical and mental condition, he requires the level of services provided by a nursing facility. If the individual with MI or MR is determined to require a nursing facility level of care, it must also be determined whether the individual requires specialized services. PASARR applies to all individuals entering or residing in a nursing facility, regardless of payment source. (7-1-06)T

02. Policy. It is the policy of the Department that the difficulty in providing specialized services in the nursing facility setting makes it generally inappropriate to place individuals needing specialized services in an nursing facility. This policy is supported by the background and development of the federal PASARR requirements, including the narrow definition of mental illness adopted by federal law. While recognizing that there are exceptions, it is envisioned that most individuals appropriate for nursing facility placement will not require services in excess of those required to be provided by nursing facilities by 42 CFR 483.45. (7-1-06)T

03. Inter-Agency Agreement. The state Medicaid agency will enter into a written agreement with the state mental health and mental retardation authorities as required in 42 CFR 431.621(c). This agreement will, among other things, set forth respective duties and delegation of responsibilities, and any supplemental criteria to be used in making determinations. (7-1-06)T

a. The "State Mental Health Authority" (SMHA) in the Division of Family and Community Services of the Department, or its successor entity. (7-1-06)T

b. The "State Mental Retardation or Developmental Disabilities Authority" (SDDA) in the Division of Family and Community Services of the Department, or its successor entity. (7-1-06)T

04. Coordination for PASARR. The PASARR process is a coordinated effort between the state Medicaid agency, the SMHA and SDDA, independent evaluators and the nursing facility. PASARR activities will be coordinated through the Regional Medicaid Services (RMS). RMS is responsible for record retention and tracking functions. However, the nursing facility is responsible for assuring that all screens are obtained and for coordination with the RMS, independent MI evaluators, the SMHA and SDDA, and their designees. Guidelines and procedures on how to comply with these requirements can be found in the "Statewide PASARR Procedures," a reference guide. (7-1-06)T

a. All required Level I screens and reviews must be completed and submitted to the RMS prior to admission to the facility. (7-1-06)T

b. When a nursing facility identifies an individual with MI or MR through a Level I screen, or otherwise, the nursing facility is responsible for contacting the SMHA or SDDA (as appropriate), and assuring that a Level II screen is completed prior to admission to the facility, or in the case of an existing resident, completed in order to continue residing in the facility. (7-1-06)T

c. Additional Resident Reviews (ARR). An individual identified with MI or MR must be reviewed and a new determination made promptly after a significant change in his physical or mental condition. The facility must notify the RMS of any such change within two (2) working days of its occurrence. For the purpose of this section, significant change for the participant's mental condition means a change which may require the provision of specialized services or an increase in such services. A significant change in physical condition is a change that renders the participant incapable of responding to MI or D.D. program interventions. (7-1-06)T

228. NURSING FACILITIY - COORDINATION OF NURSING FACILITY ELIGIBILITY AND THE NEED FOR SPECIALIZED SERVICES.
Determinations as to the need for nursing facility care and determinations as to the need for specialized services should not be made independently. Such determinations must often be made on an individual basis, taking into account the condition of the resident and the capability of the facility to which admission is proposed to furnish the care needed. When an individual identified with MI and MR is admitted to a nursing facility, the nursing facility is responsible for meeting that individual's needs, except for the provision of specialized services. (7-1-06)T

01. Level of Care. (7-1-06)T

a. Individual determinations must be based on evaluations and data as required by these rules. (7-1-06)T

b. Categorical determinations. Recognizing that individual determinations of level of care are not always necessary, those categories set forth as examples at 42 CFR 483.130(d) are hereby adopted as appropriate for categorical determinations. When nursing facility level of care is determined appropriate categorically, the individual may be conditionally admitted prior to completion of the determination for specialized services. However, conditional admissions cannot exceed seven (7) days, except for respite admissions, which cannot exceed thirty (30) consecutive days in one (1) calendar year. (7-1-06)T

02. Specialized Services. Specialized services for mental illness as defined in 42 CFR 483.120(a)(1), and for mental retardation as defined in 42 CFR 483.120(a)(2), are those services provided by the state which due to the intensity and scope can only be delivered by personnel and programs which are not included in the specialized rehabilitation services required of nursing facilities under 42 CFR 483.45. The need for specialized services must be documented and included in both the resident assessment instrument and the plan of care. (7-1-06)T

a. Individual determinations must be based on evaluations and data as required by these rules. (7-1-06)T

b. Categorical determinations that specialized services are not needed may be made in those situations permitted by 42 CFR 483.130. (7-1-06)T

03. Penalty for Non-Compliance. No payment will be made for any services rendered by a nursing facility prior to completion of the Level I screen and, if required, the Level II screen. Failure to comply with PASARR requirements for all individuals admitted or seeking admission may also subject a nursing facility to other penalties as part of certification action under 42 CFR 483.20. (7-1-06)T

04. Appeals. Discharges, transfers, and preadmission PASARR determinations may be appealed to the extent required by 42 CFR, Part 483, Subpart E, and under Section 67-5229, Idaho Code. Appeals under this paragraph are made in accordance with the fair hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-06)T

a. A Level I finding of MI or MR is not an appealable determination. It may be

disputed as part of a Level II determination appeal. (7-1-06)T

b. In the event that the PASARR program is eliminated or made non-mandatory by an act of Congress, the provisions of Section 227 of these rules will cease to be operative on the effective date of any such act, without further action. (7-1-06)T

229. NURSING FACILITY - PREPAYMENT SCREEN AND DETERMINATION OF ENTITLEMENT TO MEDICAID PAYMENT FOR NURSING FACILITY CARE AND SERVICES.

The level of care for Title XIX and Title XXI payment purposes is determined by the Regional Nurse Reviewer(s). Necessity for payment is determined in accordance with 42 CFR 483 Subpart C and Section 1919(e) (7) of the Social Security Act. In the event a required Level II screen was not accomplished prior to admission, entitlement for Medicaid payment as established by the RMS will not be earlier than the date the Level II screen is completed, indicating that nursing facility placement is appropriate. (7-1-06)T

01. Information Required For Medical Evaluation Determination. A current Minimum Data Set (MDS) assessment will be provided to the Department. Additional supporting information may be requested. (7-1-06)T

02. Information Required For Level I And II Screen Determination. An accurate Level I screen and when required, a Level II screen. (7-1-06)T

230. NURSING FACILITY - PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Application and Certification. A facility must apply to participate as a nursing facility. (7-1-06)T

02. Licensure and Certification. (7-1-06)T

a. Upon receipt of an application from a facility, the Licensing and Certification Agency determines the facility's compliance with certification standards for the type of care the facility proposes to provide to medical assistance participants. (7-1-06)T

b. If a facility proposes to participate as a skilled nursing facility, Medicare (Title XVIII) certification and program participation is required before the facility can be certified for Medicaid. The Licensing and Certification Agency must determine the facility's compliance with Medicare requirements and recommend certification to the Medicare Agency. (7-1-06)T

c. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for nursing facility care. The Department must certify to the appropriate branch of government that the facility meets the standards for nursing facility level of care. (7-1-06)T

d. Upon receipt of the certification from the Licensing and Certification Agency, the Department may enter into a provider agreement with the long-term care facility. (7-1-06)T

e. After the provider agreement has been executed by the Facility Administrator and

by the Department, one (1) copy must be sent by certified mail to the facility and the original is to be retained by the Department (7-1-06)T

232. -- 234. (RESERVED).

235. NURSING FACILITY - ~~PAYMENT METHODOLOGY~~ PROVIDER REIMBURSEMENT.

01. Payment Methodology. Nursing facilities will be reimbursed in accordance with the payment methodologies as described in Sections 236 through 295 of these rules. (7-1-06)T

02. Date of Discharge. Payment by the Department for the cost of long term care is to include the date of the participant's discharge only if the discharge occurred after 3 p.m. and is not discharged to a related ICF/MR provider. If a Medicaid patient dies in a nursing home, his date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care will be deemed to exist. (7-1-06)T

~~***03. Nonlegend Drugs Reimbursement***. (7-1-06)T~~

~~***a.*** *For providers which have no pharmacy on the premises, reimbursement will be available for nonlegend drugs subject to a test of reasonableness related to the market place and must not exceed the pharmacist's charges to private pay patients. This means that charges to the patient may not exceed the billing to the provider including, adjustments by discounts or terms.* (7-1-06)T~~

~~***b.*** *For providers who have a pharmacy on the premises, reimbursement will be available for nonlegend drugs at cost plus a dispensing fee established by the Division of Medicaid.* (7-1-06)T~~

~~***04. Record-Keeping Requirements for Drug Purchases****. According to the requirements in the PRM, Section 2104, the provider, as part of its financial record-keeping responsibility under the Medicaid Assistance Program must have on supplier invoices all needed cost verification information including name brand, quantity, form, and strength of the drugs supplied and the provider's actual cost. In the absence of such information and in accordance with Title XVIII of the Social Security Act, Section 1815 and 42 CFR 405.453, the Department must deny charges for unlabeled drugs because of inadequate records. Any cost reductions received on drug purchases including discounts, cash, trade, purchase, and quantity, or rebates, must also be clearly reflected on the individual invoices or related documentation.* (7-1-06)T~~

236. NURSING FACILITY - REASONABLE COST PRINCIPLES.
To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to ~~*beneficiaries*~~ *participants* will result. ~~(7-1-06)T~~(7-1-06)T

01. Application of Reasonable Cost Principles. (7-1-06)T

a. Reasonable costs of any services are determined in accordance with this chapter of rules found in Sections 236 through 295 of these rules, and Provider Reimbursement Manual

(PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. (7-1-06)T

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. (7-1-06)T

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. (7-1-06)T

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Idaho Code, or are unallowable by application of promulgated regulation. (7-1-06)T

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (7-1-06)T

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. (7-1-06)T

02. Costs Related to Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Example: Depreciation is a method of systematically recognizing the declining utility value of an asset. To the extent that the asset is related to patient care, reasonable, ordinary, and necessary, the related expense is allowable when reimbursed based on property costs according to other provisions of this chapter. Property related expenses are likewise allowable. (7-1-06)T

03. Costs Not Related to Patient Care. Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. Example: Fines are imposed for late remittance of federal withholding taxes. Such fines are not related to patient care, are not necessary, and are not reflective of prudent cost conscious management. Therefore, such fines and penalties are not allowable. (7-1-06)T

04. Form and Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. Example: Lease-Purchase agreements are contracts which are executed in the form of a lease. The wording of the contract is couched in such a manner as to give the reader the impression of a true rental-type lease. However, the substance of this contract is a purchase of the property. If a lease contract is found to

be in substance a purchase, the related payments are not allowable as lease or rental expense. (7-1-06)T

237. NURSING FACILITY - NOTICE OF PROGRAM REIMBURSEMENT.
Following receipt of the finalized Medicare Cost Report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. (7-1-06)T

***01. Notice**. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. (7-1-06)T*

***02. Recovery or Suspension**. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (7-1-06)T*

***03. Timing of Notice**. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the Cost Report from the Medicare Intermediary. (7-1-06)T*

***04. Reopening of Completed Settlements**. A Medicaid completed cost settlement may be reopened by the provider or the state within a three-year (3) period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the Cost Report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (7-1-06)T*

238. NURSING FACILITY - INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS.
The Title XIX and Title XXI programs will charge interest on overpayments, and pay interest on underpayments. (7-1-06)T

***01. Interest After Sixty Days of Notice**. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement, and will be charged on the unpaid settlement balance for each thirty- day (30) period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty-day (30) period, and the thirty-day (30) interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. (7-1-06)T*

***02. Waiver of Interest Charges**. When the Department determines an overpayment*

exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges. *((7-1-06)T*

03. ***Rate of Interest****. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly.* *(7-1-06)T*

04. ***Retroactive Adjustment****. The balance and interest will be retroactively adjusted to equal the amounts that would have been due based on any changes which occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties will only be applied to unpaid amounts and will be subordinated to final interest determinations made in the judicial review process.* *(7-1-06)T*

239. NURSING FACILITY - RECOVERY METHODS FOR OVERPAYMENTS.
One (1) of the following methods will be used for recovery of overpayments: *(7-1-06)T*

01. ***Lump Sum Voluntary Repayment****. Upon receipt of the notice of program reimbursement, the provider voluntarily refunds, in a lump sum, the entire overpayment to the Department.* *(7-1-06)T*

02. ***Periodic Voluntary Repayment****. The provider must request in writing that recovery of the overpayment be made over a period of twelve (12) months or less. The provider must adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested.* *(7-1-06)T*

03. ***Department Initiated Recovery****. The Department will recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receiving the notice.* *(7-1-06)T*

04. ***Recovery From Medicare Payments****. The Department can request that Medicare payments be withheld in accordance with 42 CFR, Section 405.377.* *(7-1-06)T*

~~***237. - 239. (RESERVED).***~~

240. NURSING FACILITY - ALLOWABLE COSTS.
The following definitions and explanations apply to allowable costs: (7-1-06)T

01. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable. (7-1-06)T

02. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement can not exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee. (7-1-06)T

03. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other

allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable under PRM, Section 300. (7-1-06)T

04. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (7-1-06)T

05. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Section 274 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: (7-1-06)T

a. Salaries wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (7-1-06)T

b. Supplies and services provided for the owner's personal use. (7-1-06)T

c. Compensation paid by the facility to employees for the sole benefit of the owner. (7-1-06)T

d. Fees for consultants, directors, or any other fees paid regardless of the label. (7-1-06)T

e. Keyman life insurance. (7-1-06)T

f. Living expenses, including those paid for related persons. (7-1-06)T

06. Contracted Service. All services which are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (7-1-06)T

07. Depreciation. Depreciation on buildings and equipment is an allowable property expense subject to Section 275 of these rules. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. (7-1-06)T

08. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related

to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met. (7-1-06)T

09. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. (7-1-06)T

10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable. (7-1-06)T

11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment. (7-1-06)T

12. Food. Costs of raw food, not including vending machine items, are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food. (7-1-06)T

13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers. (7-1-06)T

14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. (7-1-06)T

15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (7-1-06)T

16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices cannot be reported as property costs, but will be allowable based on reasonable cost principles subject to other limitations contained herein. (7-1-06)T

17. Malpractice and Public Liability Insurance. Premiums for malpractice and public liability insurance must be reported as administrative costs. (7-1-06)T

18. Payroll Taxes. The employer's portion of payroll taxes is reimbursable. (7-1-06)T

19. Property Costs. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. For free-standing nursing facilities, the property rental rate is paid as described in Section 275 of these rules. Hospital-based nursing facilities are paid based on property costs.

(7-1-06)T

a. Amortization of leasehold improvements will be included in property costs. (7-1-06)T

i Straight line depreciation on fixed assets is included in property costs. (7-1-06)T

ii. Depreciation of moveable equipment is an allowable property cost. (7-1-06)T

b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities. (7-1-06)T

20. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (7-1-06)T

21. Repairs and Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (7-1-06)T

22. Salaries. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost. (7-1-06)T

23. Supplies. Cost of supplies used in patient care or providing services related to patient care is allowable. (7-1-06)T

24. Taxes. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs. (7-1-06)T

241. NURSING FACILITY - NONALLOWABLE COSTS.
The following definitions and explanations apply to nonallowable costs: (7-1-06)T

01. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable. (7-1-06)T

02. Acquisitions. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable. (7-1-06)T

03. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable. (7-1-06)T

04. Charity Allowances. Cost of free care or discounted services are nonallowable. (7-1-06)T

05. Consultant Fees. Costs related to the payment of consultant fees in excess of the

lowest rate available to a facility are nonallowable. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified, unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This subsection in no way limits the Department's ability to disallow excessive consultant costs under other Sections of this chapter, such as Section 236 or 245 of these rules, when applicable. (7-1-06)T

06. **Fees**. Franchise fees are nonallowable, see PRM, Section 2133.1. (7-1-06)T

07. **Fund Raising**. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2. (7-1-06)T

08. **Goodwill**. Costs associated with goodwill as defined in Section 011 of these rules are nonallowable. (7-1-06)T

09. **Holding Companies**. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A. (7-1-06)T

10. **Interest**. Interest to finance nonallowable costs are nonallowable. (7-1-06)T

11. **Medicare Costs**. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable. (7-1-06)T

12. **Nonpatient Care Related Activities**. All activities not related to patient care are nonallowable. (7-1-06)T

13. **Organization**. Organization costs are nonallowable, see PRM, Section 2134. (7-1-06)T

14. **Pharmacist Salaries**. Salaries and wages of pharmacists are nonallowable. (7-1-06)T

15. **Prescription Drugs**. Prescription drug costs are nonallowable. (7-1-06)T

16. **Related Party Interest**. Interest on related party loans are nonallowable, see PRM, Sections 218.1 and 218.2. (7-1-06)T

17. **Related Party Nonallowable Costs**. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated. (7-1-06)T

18. **Related Party Refunds**. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related

purchases, costs, etc. (7-1-06)T

19. Self-Employment Taxes. Self-employment taxes, as defined by the Internal Revenue Service, which apply to facility owners are nonallowable. (7-1-06)T

20. Telephone Book Advertising. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable. (7-1-06)T

21. Vending Machines. Costs of vending machines and cost of the product to stock the machine are nonallowable costs. (7-1-06)T

242. NURSING FACILITY - HOME OFFICE COST PRINCIPLES.
The reasonable cost principles will extend to the home office costs allocated to individual providers. In addition, the home office, through the provider, will provide documentation as to the basis used to allocate its costs among the various entities it administers or otherwise directs. (7-1-06)T

~~***243. -- 244. (RESERVED).***~~

243. NURSING FACILITY - RELATED PARTY TRANSACTIONS.

***01. Principle**. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (7-1-06)T*

***02. Cost Allowability - Regulation**. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. (7-1-06)T*

244. NURSING FACILITY - APPLICATION OF RELATED PARTY TRANSACTIONS.

***01. Determination of Common Ownership or Control in the Provider Organization and Supply Organization**. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (7-1-06)T*

***a.** A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. (7-1-06)T*

***b.** The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. (7-1-06)T*

***02. Cost to Related Organizations**. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. (7-1-06)T*

***03. Costs Not Related to Patient Care**. All home office costs not related to patient care are not allowable under the program. (7-1-06)T*

***04. Interest Expense**. Generally, interest expense on loans between related entities will not be reimbursable. See the PRM, Chapters 2, 10, and 12 for specifics. (7-1-06)T*

245. NURSING FACILITY - COMPENSATION OF RELATED PERSONS.
Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. (7-1-06)T

01. Compensation Claimed. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. (7-1-06)T

a. Where such persons perform services without pay, no cost may be imputed. (7-1-06)T

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. (7-1-06)T

c. Compensation for undocumented hours worked will not be a reimbursable cost. (7-1-06)T

02. Related Persons. A related person is defined as having one (1) of the following relationships with the provider: (7-1-06)T

a. Husband or wife; (7-1-06)T

b. Son or daughter or a descendent of either; (7-1-06)T

c. Brother, sister, stepbrother, stepsister or descendent thereof; (7-1-06)T

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; (7-1-06)T

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; (7-1-06)T

f. A descendent of a brother or sister of the provider's father or mother; (7-1-06)T

g. Any other person with whom the provider does not have an arms length relationship. (7-1-06)T

246. NURSING FACILITY - INTEREST EXPENSE.

Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. (7-1-06)T

247. -- 249. (RESERVED).

250. NURSING FACILITY - COST LIMITS.
Sections 250 through ~~272~~ 271 of these rules, provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the nursing home reimbursement system as specified in Sections 56-101 through 56-135, Idaho Code. All audits related to fiscal years ending on or before December 31, 1999 are subject to rules in effect before July 1, 1999. ~~(7-1-06)T~~(7-1-06)T

251. (RESERVED).

252. NURSING FACILITY - PROPERTY AND UTILITY COSTS.
Whether or not each of these cost items is allowed will be determined in accordance with other provisions of this chapter, or the PRM in those cases where this the rules of this chapter are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (7-1-06)T

01. Depreciation. All allowable depreciation expense. (7-1-06)T

02. Interest. All allowable interest expense relating to financing building and equipment purchases. Interest on working capital loans will be included as administrative costs. (7-1-06)T

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs. (7-1-06)T

04. Lease Payments. All allowable lease or rental payments. (7-1-06)T

05. Property Taxes. All allowable property taxes. (7-1-06)T

06. Utility Costs. All allowable expenses for heat, electricity, water and sewer. (7-1-06)T

253. -- 254. (RESERVED).

255. NURSING FACILITY - RATE SETTING.
The objectives of the rate setting mechanism for nursing facilities are: (7-1-06)T

01. Payments. To make payments to nursing facilities through a prospective cost-based system which includes facility-specific case mix adjustments. (7-1-06)T

02. Rate Adjustment. To set rates based on each facility's case mix index on a quarterly basis and establishing rates that reflect the case mix of that facility's Medicaid residents

as of a certain date during the preceding quarter. (7-1-06)T

256. NURSING FACILITY - PRINCIPLE FOR RATE SETTING.
Reimbursement rates will be set based on projected cost data from cost reports and audit reports. Reimbursement is to be set for freestanding and hospital-based facilities. In general, the methodology will be a cost-based prospective reimbursement system with an acuity adjustment for direct care costs. (7-1-06)T

257. NURSING FACILITY - DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and rebased annually. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.09 of these rules. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. (7-1-06)T

01. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (7-1-06)T

02. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited or unaudited cost report which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 are used in setting rates effective July 1, 1999). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department. (7-1-06)T

03. Interim Rates. Nursing facilities with unaudited cost reports are given an interim rate established by the Department until a rate is calculated based on an audited cost report. When audited data are available, a retroactive adjustment to the payment rate is made through the calculation of the finalized rate. (7-1-06)T

04. Direct Care Cost Component. The direct care cost component of a nursing facility's rate is determined as follows: (7-1-06)T

a. The direct care per diem cost limit applicable to the rate period for a nursing facility type (free- standing and urban hospital-based nursing facility or rural hospital-based nursing facility) is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the nursing facility's facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit. (7-1-06)T

b. The adjusted direct care per diem cost limit is compared to the nursing facility's inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted. (7-1-06)T

i. If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by the nursing facility's facility-wide CMI for the cost reporting period, and then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component. (7-1-06)T

ii. If the inflated direct care per diem costs are lower, these costs, minus raw food and Medicaid related ancillary costs, are divided by the nursing facility's facility-wide CMI for the cost reporting period, then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component. (7-1-06)T

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities, or rural hospital-based nursing facilities. (7-1-06)T

06. Efficiency Incentive. The efficiency incentive is available to those providers, both free-standing and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by seventy percent (70%). There is no incentive available to those facilities with per diem costs in excess of the indirect care cost limit, or to any facility based on the direct care cost component. (7-1-06)T

07. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (7-1-06)T

08. Property Reimbursement. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (7-1-06)T

09. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of these rules. (7-1-06)T

258. NURSING FACILITY - COST LIMITS BASED ON COST REPORT.
Effective July 1, 1999, and each July 1st thereafter, cost limitations will be established for nursing facilities based on the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year. (7-1-06)T

01. Percentage Above Bed-Weighted Median. Prior to establishing the first “shadow rates” at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999 through June 30, 2000 will be calculated. This amount will

then be used to model the estimated payments under the case mix system set forth in Sections 255 through 257 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. Once established, these percentages will remain in effect for future rate setting periods. (7-1-06)T

02. Direct Cost Limits. The direct cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. (7-1-06)T

03. Indirect Cost Limits. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital- based nursing facilities included in the same array, and the bed-weighted median will be computed. (7-1-06)T

04. Limitation on Increase or Decrease of Cost Limits. Increases in the direct and indirect cost limits will be determined by the limitations calculated effective July 1, 1999, indexed forward each year by the inflation factor plus two percent (2%) per annum. Furthermore, the calculated direct and indirect cost limits will not be allowed to decrease below the established limitations effective July 1, 1999. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee after a three-year period to determine which factors to use in the calculation of the limitations effective July 1, 2002 and forward. (7-1-06)T

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 278 of these rules. (7-1-06)T

259. NURSING FACILITY - TREATMENT OF NEW BEDS.
Facilities that add beds after July 1, 1999, will have their reimbursement rate subjected to an additional limitation for the next three (3) years. This limitation will apply beginning with the first rate setting period which utilizes a cost report that includes the date when the beds were added. (7-1-06)T

01. Limitation of Facilities Rate. The facility's rate will be limited to the bed-

weighted average of the following two (2) rates: (7-1-06)T

a. The facility's current prospective rate calculated in accordance with Section 257 of these rules; and (7-1-06)T

b. The current median rate for nursing facilities of that type, free-standing, rural hospital-based, or urban hospital-based, established each July 1st. (7-1-06)T

02. Calculation of the Bed-Weighted Average. The current calculated facility rate is multiplied by the number of beds in existence prior to the addition. The median rate is multiplied by the number of added beds, weighted for the number of days in the cost reporting period for which they were in service. These two (2) amounts are added together and divided by the total number of beds, with the new beds being weighted if they were only in service for a portion of the year. The resulting per diem amount represents an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation receive their calculated rate. (7-1-06)T

03. Exception to New Bed Rate. The following situations will not be treated as new beds for reimbursement purposes: (7-1-06)T

a. Any beds converted from nursing facility beds to assisted living beds, can be converted back to nursing facility beds within three (3) years and not be classified as new nursing facility beds. When a nursing facility bed has been converted to an assisted living bed for three (3) or more concurrent years and the bed is converted back to a nursing facility bed, it must be treated as a new nursing facility bed. (7-1-06)T

b. Beds added as a result of expansion plans, which the Department was aware of prior to July 1, 1999, will not be treated as new beds. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning, and development. The existence of adequate land or space at the nursing facility does not by itself constitute a significant expenditure of resources for the purposes of expansion. A written request with adequate supporting documentation for an exception under this provision must have been received by the Department no later than December 31, 1999. In no case will beds added after July 1, 2003, qualify for this exception to the new bed criteria. (7-1-06)T

c. Beds which are decertified as a requirement of survey and certification due to deficiencies at the facility can be re-certified as existing beds with the approval of the Department. (7-1-06)T

d. When a facility can demonstrate to the Department that adding beds is necessary to meet the needs of an under served area, these beds will not be treated as new beds. For an existing facility the new beds are reimbursed at the same reimbursement rate for that facility's existing beds. For a new facility, the reimbursement rate is negotiated with the Department. (7-1-06)T

260. NURSING FACILITY - TREATMENT OF NEW FACILITIES.
Facilities constructed subsequent to July 1, 1999, will be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first three (3) full years of operation. During the period of limitation, the facility's rate will be modified each July 1st to

reflect the current median rate for skilled care facilities of that type. After the first three (3) full years, the facility will have its rate established at the next July 1st with the existing facilities in accordance with Section 257 of this rule. (7-1-06)T

261. NURSING FACILITY - TREATMENT OF A CHANGE IN OWNERSHIP.
New providers resulting from a change in ownership of an existing facility will receive the previous owner's rate until such time as the new owner has a cost report which qualifies for the rate setting criteria established under these rules. (7-1-06)T

262. NURSING FACILITY - OUT-OF-STATE NURSING HOMES.
The Idaho Medicaid Program will reimburse for out-of-state nursing home placements when services are not available in Idaho to meet the participant's medical need, or in a temporary situation for a limited period of time required to safely transport the participant to an Idaho facility. Reimbursement for out-of-state nursing homes will be at the per diem rate set by the Medicaid Program in the state where the nursing home is located. Special rates will be allowed according to Section 270 of these rules. (7-1-06)T

263. NURSING FACILITY - DISTRESSED FACILITY.
If the Department determines that a facility is operationally or financially unstable, is located in an under-served area, or addresses an under-served need, the Department may negotiate a reimbursement rate different than the rate then in effect for that facility. (7-1-06)T

264. NURSING FACILITY - INTERIM ADJUSTMENTS TO RATES AS A RESULT OF NEW MANDATES.
Certain costs may be excluded from the cost limit calculations, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rates as provided in this Section to assure equitable reimbursement: (7-1-06)T

01. Changes of More Than Fifty Cents Per Patient Day in Costs. Changes of more than fifty cents ($.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits. (7-1-06)T

a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates. (7-1-06)T

b. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately. (7-1-06)T

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (7-1-06)T

02. Interim Rate Adjustments. For interim rate purposes, the provider may be granted an increase in its prospective rate to cover such cost increases. A cost statement covering

a recent period may be required with justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (7-1-06)T

03. Future Treatment of Costs. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed. (7-1-06)T

265. NURSING FACILITY - MDS REVIEWS.
The following Minimum Data Set (MDS) reviews will be conducted: (7-1-06)T

01. Facility Review. Subsequent to the picture date, each facility will be sent a copy of its resident roster (a listing of residents, their RUG classification, case mix index, and identification as Medicaid or other). It will be the facility's responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the Department in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the Department, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent Departmental review. (7-1-06)T

02. Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data. (7-1-06)T

266. -- 269. (RESERVED).

270. NURSING FACILITY - SPECIAL RATES.
A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117, Idaho Code, provides authority for the Department to pay facilities an amount in addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated pursuant to the principles found in Section 56-102, Idaho Code. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and these rules. (7-1-06)T

01. Determination. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-

Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than two (2) weeks. (7-1-06)T

02. Effective Date. Upon approval, a special rate is effective on the date the application was received, unless the provider requests a retroactive effective date. Special rates may be retroactive for up to thirty (30) days prior to receipt of the application. (7-1-06)T

03. Reporting. Costs equivalent to payments for special rate add-on amounts must be removed from the cost components subject to limits, and be reported separately by the provider. (7-1-06)T

04. Limitation. A special rate cannot exceed the provider's charges to other patients for similar services. (7-1-06)T

05. Prospective Rate Treatment. Prospective treatment of special rates became effective July 1, 2000. Subsections 270.06 and 270.07 of these rules provide clarification of how special rates are paid under the prospective payment system. (7-1-06)T

06. Determination of Payment for Qualifying Residents. Special rate add-on amounts are calculated using one (1) of the methods described in Subsections 270.06.a. through 270.06.e. of these rules. (7-1-06)T

a. Special Care Units. If a facility operates a special care unit, such as a behavioral unit or a Traumatic Brain Injury (TBI) unit, reimbursement is determined as described in Subsections 270.06.a.i. through 270.06.a.v. of these rules. (7-1-06)T

i. If the facility is below the direct care cost limit with special care unit costs included, no special rate is paid for the unit. (7-1-06)T

ii. If the facility is over the direct care cost limit with special care unit costs included, a special rate add-on amount will be calculated. The special rate add-on amount for the unit is the lesser of the per diem amount by which direct care costs exceed the limit or a calculated add-on amount. The calculated special rate add-on is derived as follows: each Medicaid resident is assigned a total rate equal to the Medicare rate that would be paid if the resident were Medicare eligible. The resident's acuity adjusted Medicaid rate, based on each resident's individual Medicaid CMI, is subtracted from the Medicare rate. The average difference between the Medicaid and the Medicare rates for all special care unit residents is the calculated special rate add-on amount. The calculated special rate add-on amount is compared to the per diem amount by which the provider exceeds the direct care limit. The lesser of these two amounts is allowed as the special rate add-on amount for the unit. (7-1-06)T

iii. New Unit Added After July 1, 2000. The Department must approve special rates for new special care units or increases to the number of licensed beds in an existing special care unit. Since a new unit will not have the cost history of an existing unit, the provider's relationship to the cap will not be considered in qualifying for a special rate. New units approved for special rates will have their special add-on amount calculated as the difference between the applicable Medicare price under PPS, and the acuity adjusted Medicaid rate for all unit residents as

explained in Section 311.06.a.iii. of these rules. However, the average of these amounts is not limited to the amount the provider is over the direct care cost limit, as the costs of the unit are not in the rate calculation. (7-1-06)T

iv. One Hundred Percent (100%) Special Care Facility Existing July 1, 2000. If on July 1, 2000, an entire facility was a special care unit which included Medicaid residents, the facility's direct care cost per diem will not be subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of the facility's Medicaid CMI for the rate period to the facility-wide CMI for the cost reporting period. (7-1-06)T

v. Unit Routine Customary Charge. If the cost to operate a special care unit is being included in a facility's rate calculation process, the facility must report its usual and customary charge for a semi-private room in the unit on the quarterly reporting form, in addition to the semi-private daily room rate for the general nursing home population. A weighted average routine customary charge is computed to represent the composite of all Medicaid residents in the facility based on the type of rooms they occupy, including the unit. (7-1-06)T

b. Equipment and Non-Therapy Supplies. Equipment and non-therapy supplies not adequately addressed in the current RUG system, as determined by the Department, are reimbursed at invoice cost as an add-on amount. (7-1-06)T

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. The facility need not exceed the direct care limit to receive a special rate for ventilator care and tracheostomy care. In the case of ventilator dependent and tracheostomy residents, a two (2) step approach is taken to establish an add-on amount. The first step is the calculation of a staffing add-on for the cost, if any, of additional direct care staff required to meet the exceptional needs of these residents. The add-on is calculated following the provisions in Subsection 270.06.d. of these rules, adjusted for the appropriate skill level of care staff. The second step is the calculation of an add-on for equipment, supplies, or both up to the invoice cost or rental amount. The combined amount of these two (2) components is considered the special add-on amount to the facility's rate for approved residents receiving this care. (7-1-06)T

d. Residents Not Residing in a Special Care Unit Requiring One-to-One Staffing Ratios. Facilities may at times have residents who require unusual levels of staffing, such as one-to-one staffing ratios. If the resident qualifies for a special rate, an hourly add-on rate is computed for reimbursement of approved one-to-one (1 to 1) hours in excess of the minimum staffing requirements in effect for the period. The hourly add-on rate is equal to the current WAHR CNA wage rate plus a benefits allowance of thirty percent (30%), then weighted to remove the CNA Minimum daily staffing time. (7-1-06)T

e. Varying Levels of One-to-One Care. For varying levels of one-to-one care, such as eight (8) hours or twenty-four (24) hours, the total special rate add-on amount is calculated as the number of hours approved for one- to-one care times the hourly add-on rate as described in Subsection 270.06.d. The WAHR CNA wage rate as described in Section 307 of these rules will be updated prior to the July 1st rate setting each year. Should the WAHR survey be discontinued, the Department may index prior amounts forward, or conduct a comparable survey. (7-1-06)T

07. Treatment of the Special Rate Cost for Future Rate Setting Periods. Special

rates are established on a prospective basis similar to the overall facility rate. When the cost report used to set a prospective rate contains non-unit special rate cost, an adjustment is made to "offset," or reduce costs by an amount equal to total incremental revenues, or add-on payments received by the provider during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. No related adjustment is made to the facility's CMIs. (7-1-06)T

271. NURSING FACILITY - OVERSIGHT COMMITTEE.
The Director will appoint an oversight committee to monitor implementation of the Prospective Payment System (PPS) for nursing facility reimbursement that takes effect July 1, 1999. The committee will be made up of at least one (1) member representing each of the following organizations: the Department, the state association(s) representing free standing skilled care facilities, and the state association(s) representing hospital-based skilled care facilities. The committee will continue to meet periodically subsequent to the implementation of the PPS. After three (3) years of implementation, the committee will examine the inflation factors used to inflate costs forward for rate setting (DRI + one percent (+1%), the inflation factors used in limiting the growth in the cost component limitations (DRI + two percent (+2%), and the level of the minimum cost component limitations (not lower than limits established July 1, 1999). (7-1-06)T

272. NURSING FACILITY - ~~*DISPUTES*~~ *LEGAL CONSULTANT FEES AND LITIGATION COSTS*.
Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the following: *(7-1-06)T*

01. ~~***Administrative Review Requirement**. If any facility wishes to contest the way in which a rule or contract provision relating to the prospective, cost-related reimbursement system was applied to such facility by the Director, it will first pursue the administrative review process set forth in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."*~~ ***In General**. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare, will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days.* ~~*(7-1-06)T*~~*(7-1-06)T*

02. ~~***Legal Challenge**. The administrative review process need not be exhausted if a facility wishes to challenge the legal validity of a statute, rule, or contract provision.*~~ ***Administrative Appeals**. In the case of the provider contesting in administrative appeal the findings of an audit performed by the Department of Health and Welfare, the costs of the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The determination of the extent that the provider prevails will be based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator.* ~~*(7-1-06)T*~~*(7-1-06)T*

03. ***Other**. All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law.* *(7-1-06)T*

273. NURSING FACILITY - PATIENT FUNDS.
The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. (7-1-06)T

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (7-1-06)T

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (7-1-06)T

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (7-1-06)T

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or his agent in writing. (7-1-06)T

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (7-1-06)T

03. Fund Management. Proper management of such funds would include the following as minimum: (7-1-06)T

a. Savings accounts, maintained separately from facility funds. (7-1-06)T

b. An accurate system of supporting receipts and disbursements to patients. (7-1-06)T

c. Written authorization for all deductions. (7-1-06)T

d. Signature verification. (7-1-06)T

e. Deposit of all receipts of the same day as received. (7-1-06)T

f. Minimal funds kept in the facility. (7-1-06)T

g. As a minimum these funds must be kept locked at all times. (7-1-06)T

h. Statement of policy regarding patient's funds and property. (7-1-06)T

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (7-1-06)T

j. System of periodic review and correction of policies and financial records of

patient property and funds. (7-1-06)T

274. NURSING FACILITY - IDAHO OWNER-ADMINISTRATIVE COMPENSATION.
Allowable compensation to owners and persons related to owners who provide any administrative services will be limited based on the schedule in this section. (7-1-06)T

01. Allowable Owner Administrative Compensation. The following schedule will be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, 2002.

Licensed Bed Range	Upper limit
51 - 100	86,951
101 - 150	95,641
151 - 250	129,878
251 - up	186,435

(7-1-06)T

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section will be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by Data Resources Incorporated, its successor organization or, if unavailable, another nationally recognized forecasting firm. (7-1-06)T

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 274.01 of these rules. Allowable compensation will be determined as follows: (7-1-06)T

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services will be counted, regardless of whether they are in the same facility. (7-1-06)T

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation. (7-1-06)T

c. For owners providing services to less than fifty-one (51) beds, such services related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and will be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service will be documented. In no event will the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative

services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 274.01 of these rules. (7-1-06)T

04. Compensation for Persons Related to an Owner. Compensation for persons related to an owner will be evaluated in the same manner as for an owner. (7-1-06)T

05. When an Owner Provides Services to More Than One Provider. When an owner provides services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for non-owners. (7-1-06)T

06. More Than One Owner or Related Party May Receive Compensation for Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured will be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and will not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, will not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080). (7-1-06)T

275. NURSING FACILITY - PROPERTY RENTAL RATE REIMBURSEMENT.
Free standing nursing facilities other than hospital based nursing facilities will be paid a property rental rate. Property taxes and property insurance will be reimbursed as costs exempt from limitations. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit for free-standing nursing facilities, an interim rate for property reimbursement will be set to approximate the property rental rate as determined by Sections 56-108 and 56-109, Idaho Code. (7-1-06)T

01. Property Rental Rate. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to Section 275.01 of these rules, and, beginning April 1, 1985, will be: (7-1-06)T

R = “Property Base” x 40 - “Age” / 40 x “change in building costs” where: (7-1-06)T

a. “R” = the property rental rate. (7-1-06)T

b. “Property Base” = thirteen dollars and nineteen cents ($13.19) beginning October 1, 1996 for all freestanding nursing facilities. (7-1-06)T

c. “Change in building costs” = 1.0 from October 1, 1996, through December 31, 1996. Beginning January 1, 1997, “change in building costs” will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as published by the Marshall Swift Valuation Service or the consumer price index for renter’s costs whichever is greater. For freestanding nursing facilities, the index available in

September of the prior year will be used. (7-1-06)T

d. "Age" of facility - The effective age of the facility in years will be set by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof will be assigned an age of more than thirty (30) years, however: (7-1-06)T

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age will be set at thirty (30) years. Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness. An age will be determined for each building. A weighted average using the age and square footage of the buildings will become the effective age of the facility. The age of each building will be based upon the date when construction on that building was completed. This age will be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula: (7-1-06)T

$$r = A \times E / S \times C$$

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 275.01.d.ii.

If the result of this calculation, "r" is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0). (7-1-06)T

ii. Historical nursing home construction cost per square foot for purposes of evaluating facility age.

Age	Year	Cost	Age	Year	Cost	Age	Year	Cost
1	2004	82.41	2	2003	80.80	3	2002	79.06
4	2001	78.43	5	2000	74.34	6	1999	71.55
7	1998	71.34	8	1997	68.20	9	1996	67.59
10	1995	66.19	11	1994	64.14	12	1993	60.56
13	1992	59.03	14	1991	56.13	15	1990	54.61
16	1989	53.17	17	1988	52.03	18	1987	51.66
19	1986	51.56	20	1985	50.55			

(7-1-06)T

iii. For rates paid after June 30, 1989, the effective age of a facility will be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 275.01.d.i. of these rules. However, such change will not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate "r" for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for "C" will be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider's responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs. (7-1-06)T

iv. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility. (7-1-06)T

v. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 275.01.d.iii. and 275.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of the financial burden to the state of subsequent property rate increases for a current or successor provider. (7-1-06)T

vi. Effective July 1, 1991, for freestanding nursing facilities, "age of facility" will be a revised age which is the lesser of the age established under other provisions of this Section or the age which most closely yields the rate allowable to existing facilities as of June 30, 1991, under Subsection 275.01 of these rules. This revised age will not increase over time. (7-1-06)T

02. Grandfathered Rate. A "grandfathered property rental rate" for existing free-standing nursing facilities will be determined by dividing the audited allowable annualized property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985, by the total patient days in the period July 1, 1984, through June 30, 1985. (7-1-06)T

a. Prior to audit settlement, the interim rate for property costs allowable as of January 1, 1985, will be used to approximate the grandfathered rate. (7-1-06)T

b. The grandfathered property rental rate will be adjusted to compensate the facility

for the property costs of major repairs, replacement, expansion, remodeling or renovation initiated prior to April 1, 1985, and completed during calendar year 1985. (7-1-06)T

c. Beginning July 1, 1989, facilities receiving grandfathered rates may have those rates adjusted for modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1986, if the cost of these modifications would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 275.01.d.i.of these rules. The grandfathered rate will be revised after completion of modifications and will be the greater of: (7-1-06)T

i. The grandfathered rate previously allowed; or (7-1-06)T

ii. The actual per diem property costs of amortization, depreciation and interest not applicable to the modifications for the audit period in which the modifications were completed plus the per diem rate of the first year amortization of the cost of these modifications when amortized over American Hospital Association guideline useful life or lives. However, no change in the grandfathered rate will be allowed to change that rate by more than three-fourths (3/4) of the difference between the previous grandfathered rate and the property rental rate that would be paid for a new building at the time of the proposed rate revision. (7-1-06)T

d. The facility will be reimbursed a rate which is the higher of the grandfathered property rental rate as determined according to provisions of Subsection 275.02 of these rules or the property rental rate determined according to Subsections 275.01, 275.03, or 275.05 of these rules. (7-1-06)T

03. Leased Freestanding Nursing Facilities. Freestanding nursing facilities with leases will not be reimbursed in the same manner specified in Subsections 275.01 and 275.02 of these rules. Provisions in this section do not apply to reimbursement of home office costs. Home office costs will be paid based on reasonable cost principles. (7-1-06)T

a. Facilities with leases entered into on or after March 30, 1981, are to be reimbursed in the same way as owned facilities with ownership costs being recognized instead of lease costs. (7-1-06)T

b. Facilities with leases entered into prior to March 30, 1981, will not be subject to reimbursement according to the provisions of Subsections 275.01 or 275.02 of these rules. Their property rental rate per day of care will be the sum of the annualized allowed lease costs and the other annualized property costs for assets on hand as of January 1, 1985, exclusive of taxes and insurance when paid separately, divided by total patient days in the period June 30, 1983, through July 1, 1984. (7-1-06)T

i. Effective July 1, 1989, the property rental rates of leased nursing facilities with leases entered into prior to March 30, 1981, may be adjusted to compensate for increased property costs resulting from facility modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1985, if the cost would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 275.01.d.i. of these rules. The rate will be revised after the completion of such modifications and will be the greater of the property rental rate previously allowed under Subsection 275.03, or the actual per diem property

costs for the amortization, depreciation, and interest not applicable to the modifications for the reporting period in which the modifications were completed, plus the per diem of the first year amortization of the modification expenses using the American Hospital Association guideline useful life of lives. However, no such rate change will increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the previous rate and the property rental rate that would be allowed for a new building at the time of the proposed rate revision. (7-1-06)T

ii. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement will be at a rate per day of care which reflects the increase in the lease rate. (7-1-06)T

iii. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement will be at a rate per day of care which reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters' costs. After April 1, 1985, if such a lease is terminated or if the lease allows the lessee the option to terminate other than by an option to purchase the facility, the property rental rate will become the amount "R" determined by the formula in Subsection 275.01 of these rules as of the date on which the lease is or could be terminated. (7-1-06)T

04. Sale of a Facility. In the event of the sale of a facility, or asset of a facility, the buyer will receive the property rental rate of Subsection 275.01 of these rules, except in the event of a forced sale or except in the event of a first sale of a facility receiving a "grandfathered rate" after June 30, 1991, whereupon the property rental rate of the new owner will be computed as if no sale had taken place. (7-1-06)T

05. Forced Sale of a Facility. In the event of a forced sale of a facility, or asset of a facility, where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon his incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, not modified by Section 275 of these rules**,** whichever is higher, but not exceeding the rate that would be due the seller. (7-1-06)T

276. -- 277. (RESERVED).

278. NURSING FACILITY - OCCUPANCY ADJUSTMENT FACTOR.
In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows: (7-1-06)T

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Section 013 of these rules. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs.

(7-1-06)T

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. (7-1-06)T

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories. (7-1-06)T

04. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. (7-1-06)T

05. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. (7-1-06)T

279. NURSING FACILITY - RECAPTURE OF DEPRECIATION.
Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. (7-1-06)T

01. Amount Recaptured. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken. (7-1-06)T

02. Time Frame. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. (7-1-06)T

280. NURSING FACILITY - REPORTING SYSTEM.
The objective of the reporting requirements is to provide a uniform system of periodic reports which will allow: (7-1-06)T

01. Basis for Reimbursement. A basis of provider reimbursement approximating actual costs. (7-1-06)T

02. Disclosure. Adequate financial disclosure. (7-1-06)T

03. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis. (7-1-06)T

04. Criteria. Criteria for evaluating policies and procedures. (7-1-06)T

281. NURSING FACILITY - REPORTING SYSTEM PRINCIPLE AND APPLICATION.
The provider will be required to file mandatory annual cost reports. (7-1-06)T

01. Cost Report Requirements. The fiscal year end cost report filing must include: (7-1-06)T

a. Annual income statement (two (2) copies); (7-1-06)T

b. Balance sheet; (7-1-06)T

c. Statement of ownership; (7-1-06)T

d. Schedule of patient days; (7-1-06)T

e. Schedule of private patient charges; (7-1-06)T

f. Statement of additional charges to residents over and above usual monthly rate; and (7-1-06)T

g. Other schedules, statements, and documents as requested. (7-1-06)T

~~***02. Cost Statement Requirements**. Quarterly and short period cost statement filings must include:* (7-1-06)T~~

~~***a.** Filed not later than sixty (60) days after the close of the period. Reports received after this time will be accepted at the option of the Department.* (7-1-06)T~~

~~***b.** Statement of current costs to include at least one (1) quarter (or adjusted quarter, if applicable). Statement may also be filed for any period beginning and ending with quarters of the provider's fiscal year. Other reporting period may be requested.* (7-1-06)T~~

~~***c.** Schedule of patient days.* (7-1-06)T~~

~~***d.** Schedule of all patient charges.* (7-1-06)T~~

~~***e.** Other schedules, statements, and clarifications as requested.* (7-1-06)T~~

0~~3~~2. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance. (7-1-06)T

0~~4~~3. Criteria of Reports. All reports must meet the following criteria: (7-1-06)T

a. State approved formats must be used. (7-1-06)T

b. Presented on accrual basis. (7-1-06)T

c. Prepared in accordance with generally accepted accounting principles and principles of reimbursement. (7-1-06)T

d. Appropriate detail must be provided on supporting schedules or as requested. (7-1-06)T

0~~5~~4. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant. (7-1-06)T

0~~6~~5. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. (7-1-06)T

0~~7~~6. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements must be met: (7-1-06)T

a. Outgoing management or administration must file an adjusted-period cost report if ~~*it is necessary*~~ *they are being reimbursed on a retrospective basis at the time of the charge*. This report must meet the criteria for annual cost reports, except that it must be filed not later than sixty (60) days after the change in management or ownership *for the purpose of computing a final program settlement*. ~~*(7-1-06)T*~~(7-1-06)T

b. The Department may require an appraisal at the time of a change in ownership. (7-1-06)T

c. *Providers who are receiving a new provider rate or being reimbursed on a prospective basis, when the change of management or ownership occurs, will not be required to file a closing cost report.* *(7-1-06)T*

282. NURSING FACILITY - REPORTING PERIOD.
For purposes of nursing facility rate setting, cost report periods of less than six (6) months will not be used. If a provider changes their fiscal year-end or experiences a change in ownership, the last cost report filed by that facility that is greater than six (6) months will be used until a cost report exceeding six (6) months is received from the new owner, or is based on the new fiscal year. (7-1-06)T

283. NURSING FACILITY - FILING DATES.

01. Deadlines. ~~*Deadlines for filing quarterly cost statements will be sixty (60) days after the close of the quarter so reported*~~. Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. ~~*(7-1-06)T*~~(7-1-06)T

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. (7-1-06)T

284. NURSING FACILITY - FAILURE TO FILE.
Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's interim rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. (7-1-06)T

285. NURSING FACILITY - ACCOUNTING SYSTEM.
Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. (7-1-06)T

286. NURSING FACILITY - AUDITS.
~~*The objectives of an audit are that a*~~ All financial reports are subject to audit by Departmental representatives~~ *as described in Sections 286 through 288 of these rules*~~. ~~*(7-1-06)T*~~(7-1-06)T

01. Accuracy of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (7-1-06)T

02. Reliability of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results of the to the provider's operations. (7-1-06)T

03. Economy and Efficiency. To determine if Title XIX and Title XXI participants have received the required care on the a basis of economy and efficiency. (7-1-06)T

04. Application of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (7-1-06)T

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding his fiduciary responsibilities for patients, funds and property. (7-1-06)T

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (7-1-06)T

07. Compliance. To provide recommendations which will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program participants. (7-1-06)T

08. Final Settlement. To effect final settlement when required by **Sections** 250 through 296 of these rules. (7-1-06)T

287. NURSING FACILITY - AUDIT APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year. (7-1-06)T

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. (7-1-06)T

03. Additional Audits. In addition, audits may be required where: (7-1-06)T

a. A significant change of ownership occurs. (7-1-06)T

b. A change of management occurs. (7-1-06)T

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. (7-1-06)T

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. (7-1-06)T

288. NURSING FACILITY - AUDIT STANDARDS AND REQUIREMENTS.

01. Review of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. (7-1-06)T

02. Requirements. Providers Reimbursement Manual (PRM), Section 2404.3, states: “Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary. (7-1-06)T

03. Examination of Records. Examination of records and documents may include: (7-1-06)T

a. Corporate charters or other documents of ownership including those of a parent or related companies. (7-1-06)T

b. Minutes and memos of the governing body including committees and its agents. (7-1-06)T

c. All contracts. (7-1-06)T

d. Tax returns and records, including workpapers and other supporting documentation. (7-1-06)T

e. All insurance contracts and policies including riders and attachments. (7-1-06)T

f. Leases. (7-1-06)T

g. Fixed asset records (see audit section - Capitalization of Assets). (7-1-06)T

h. Schedules of patient charges. (7-1-06)T

i. Notes, bonds and other evidences of liability. (7-1-06)T

j. Capital expenditure records. (7-1-06)T

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. (7-1-06)T

l. Evidence of litigations the facility and its owners are involved in. (7-1-06)T

m. Documents of ownership including attachments which describe the property. (7-1-06)T

n. All invoices, statements and claims. (7-1-06)T

o. Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit work papers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request, under PRM, Subparagraph 2404.4(Q). (7-1-06)T

p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (7-1-06)T

q. All patient records, including trust funds and property. (7-1-06)T

r. Time studies and other cost determining information. (7-1-06)T

s. All other sources of information needed to form an audit opinion. (7-1-06)T

04. Adequate Documentation. (7-1-06)T

a. Adequate cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, and other documentation which pertains to the determination of reasonable cost, capable of being audited under PRM, Section 2304. (7-1-06)T

b. Adequate expenses documentation including an invoice, or a statement with invoices attached which support the statement. All invoices should meet the following standards: (7-1-06)T

i. Date of service or sale; (7-1-06)T

ii. Terms and discounts; (7-1-06)T

iii. Quantity; (7-1-06)T

iv. Price; (7-1-06)T

v. Vendor name and address; (7-1-06)T

vi. Delivery address if applicable; (7-1-06)T

vii. Contract or agreement references; and (7-1-06)T

viii. Description, including quantity, sizes, specifications brand name, services performed. (7-1-06)T

c. Capitalization of assets for major movable equipment will be capitalized. Minor movable equipment cannot be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. (7-1-06)T

d. Completed depreciation records must meet the following criteria for each asset: (7-1-06)T

i. Description of the asset including serial number, make, model, accessories, and location. (7-1-06)T

ii. Cost basis should be supported by invoices for purchase, installation, etc. (7-1-06)T

iii. Estimated useful life. (7-1-06)T

iv. Depreciation method such as straight line, double declining balance, etc. (7-1-06)T

v. Salvage value. (7-1-06)T

vi. Method of recording depreciation on a basis consistent with accounting policies. (7-1-06)T

vii. Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. (7-1-06)T

viii. Reported depreciation expense for the year and accumulated depreciation will tie to the asset ledger. (7-1-06)T

e. Depreciation methods such as straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (7-1-06)T

f. The depreciable life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 1993 revised edition. Guidelines Lives, which is incorporated by reference under Section 004 of these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. (7-1-06)T

g. Lease purchase agreements may generally be recognized by the following characteristics: (7-1-06)T

i. Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (7-1-06)T

ii. Intent to create security interest; (7-1-06)T

iii. Lessee may acquire title through exercise of purchase option which requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (7-1-06)T

iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and (7-1-06)T

v. Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (7-1-06)T

h. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. (7-1-06)T

i. Complete personnel records normally contain the following: (7-1-06)T

i. Application for employment. (7-1-06)T

ii. W-4 Form. (7-1-06)T

iii. Authorization for other deductions such as insurance, credit union, etc. (7-1-06)T

iv. Routine evaluations. (7-1-06)T

v. Pay raise authorization. (7-1-06)T

vi. Statement of understanding of policies, procedures, etc. (7-1-06)T

vii. Fidelity bond application (where applicable). (7-1-06)T

05. Internal Control. (7-1-06)T

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (7-1-06)T

i. Safeguarding assets and resources against waste, fraud, and inefficiency. (7-1-06)T

ii. Promoting accuracy and reliability in financial records. (7-1-06)T

iii. Encouraging and measuring compliance with company policy and legal requirements. (7-1-06)T

iv. Determining the degree of efficiency related to various aspects of operations. (7-1-06)T

b. An adequate system of internal control over cash disbursements would normally include: (7-1-06)T

i. Payment on invoices only, or statements supported by invoices. (7-1-06)T

ii. Authorization for purchase such as a purchase order. (7-1-06)T

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (7-1-06)T

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (7-1-06)T

v. Check of invoice accuracy. (7-1-06)T

vi. Approval policy for invoices. (7-1-06)T

vii. Method of invoice cancellation to prevent duplicating payment. (7-1-06)T

viii. Adequate separation of duties between ordering, recording, and paying. (7-1-06)T

ix. System separation of duties between ordering, recording, and paying. (7-1-06)T

x. Signature policy. (7-1-06)T

xi. Pre-numbered checks. (7-1-06)T

xii. Statement of policy regarding cash or check expenditures. (7-1-06)T

xiii. Adequate internal control over the recording of transactions in the books of record. (7-1-06)T

xiv. An imprest system for petty cash. (7-1-06)T

06. Accounting Practices. Sound accounting practices normally include the following: (7-1-06)T

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (7-1-06)T

b. Chart of accounts. (7-1-06)T

c. A budget or operating plan. (7-1-06)T

289. (RESERVED).

290. NURSING FACILITY - ANCILLIARY AND ROUTINE NURSING SUPPLIES.

01. Ancillary Supplies.

Ancillary Supplies
Artificial Limbs
Canes
Laboratory Tests
Legend Drugs and Insulin paid to facilities on a patient and prescription specific basis
Radiology
X-ray

(7-1-06)T

02. Routine Supplies.

.

Routine Supplies	
A	
A & D Ointment	Alcohol Applicators

Routine Supplies	
ABD Pad	Arm Slings
Ace Bandages	Asepto Syringes
Acquamatic K Pads	Autoclave Sheets
Air Mattress	
B	
Baby Powder	Bed Pans
Band Aid Spots	Bedside Tissues
Band Aids	Benzoin Aerosol
Bandages/Elastic	Bibs
Bandages/Sterile	Bottles/Specimen
Basins	Braces
Bed Frame Equipment	
C	
Cannula/Nasal	Clinitest
Catheter Clamp	Clysis Set
Catheter Plug	Coloplast
Catheter Tray	Cotton Balls
Catheters, any size	Crutches
Catheters/Irrigation	
D	
Decubitus Ulcer Pads	Douche Bags
Defecation Pads	Drainage Bags
Denture Cup	Drainage Sets
Deodorant	Drainage Tubing
Dermassage	Dressing/Sterile
Disposable Leg Bag	Dressing Tray
Disposable Underpads	Drugs Nonlegend
Donut Pad	
E	
Enema Cans/Disposable	Enema/Fleets in Oil
Enema/Fleets	
F	
Female Urinal	Flotation Mattress
Finger Cots	Foot Cradle

Routine Supplies	
Flex Straws	
G	
Gastric Feeding Tube	Gloves/Sterile
Gloves/Nonsterile	Gowns
H	
Hand Feeding	Heel Protectors
Harris Flush Tube	Hexol
Heat Cradle	Hot Pack Machine
Heating Pad	
I	
Ice Bag	Irrigation Bulb
Identification Bands	Irrigation Set
Incontinency Care	Irrigation Solution
Invalid Ring	Irrigation Tray
IPPB Machine	IV Set
J	
Jelly/Lubricating	
K	
Killet Ampules	Kling bandages/Sterile
Kleenex	KY Jelly
L	
Levine Tube	Lotion
Linen	
M	
Maalox	Medicine Dropper
Male Urinal	Merthiolate Spray
Massages	Milk of Magnesia
Medical Social Services	Mineral Oil
Medicine Cups	Mouthwashes
N	
Nasal Cannula	Needles
Nasal Catheter	Nonallergic Tape (paper tape)
Nasal Gastric Tube	Nursing Services
Nasal Tube	

Routine Supplies	
O	
Occupational Therapy	Oxygen Equipment-IPPB
Ointment/Skin Nonprescription	Oxygen Mask/Disposable
Overhead Trapese	Oxygen/Nondisposable
Oxygen	
P	
Peroxide	Physical Therapy (subject to Department policy)
Personal Laundry (except for dry cleaning and special laundry)	Plastic Bib
Pitcher	Pumps (subject to Department policy)
R	
Rectal Tube	Room and Board
Restraints	
S	
Sand Bags	**S**Stomach Tube
Scalpel	Suction Machines
Sheep Skin	Suppositories
Special Diets	Surgical Dressings
Specimen Cup	Surgical Pads
Speech Therapy	Surgical Tape/Nonallergic
Sponges/Sterile	Suture Set Suture Tray
Sterile Pads	Swabs/Lemon & Glycerin
T	
Tape (Lab-Testing)	Tracheostomy Sponges
Tape/Autoclave	Tray Service
Testing Sets/Refills	Tubing/IV
Thermometers	Tubing/Blood
Tincture of Benzoin	Tubing/Drainage
Tongue Blades	
U	
Urinals	Urological Solutions
Urinary Drainage Tube Underpads (if more than occasional use)	
V	

Routine Supplies	
Vaseline	
W	
Walkers	Wheel Chairs
Water Pitchers	Water for Injection

(7-1-06)T

291. NURSING FACILITY - COSTS FOR THE COMPLETION OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS (NATCEPS) AND FOR COMPLYING WITH CERTAIN OTHER REQUIREMENTS.
Provisions of federal law require the state to give special treatment to costs related to the completion of training and competency evaluation of nurse aides and to increase rates related to other new requirements. Treatment will be as follows: (7-1-06)T

01. Cost Reimbursement. Effective for cost reports filed and for payments made after April 1, 1990, NATCEP costs will be outside the content of nursing facility care and will be reported separately as exempt costs. (7-1-06)T

02. Costs Subject to Audit. Such NATCEP costs are subject to audit, and must be reported by all nursing facilities, including those that are hospital-based, and are not included in the percentile cap. (7-1-06)T

292. NURSING FACILITY - PAYMENTS FOR PERIODS OF TEMPORARY ABSENCE.
Payments may be made for reserving beds in long-term care facilities for participants during their temporary absence if the facility charges private paying patients for reserve bed days, subject to the following limitations: (7-1-06)T

01. Facility Occupancy Limits. Payment for periods of temporary absence from long term care facilities will not be made when the number of unoccupied beds in the facility on the day preceding the period of temporary absence in question is equal to or greater than: (7-1-06)T

a. If licensed beds are less than one hundred (<100) and they have five (5) or more beds unoccupied, leave of absence payments are not allowed. (7-1-06)T

b. If licensed beds are greater than or equal to one hundred (≥100), they must have a minimum occupancy rate of ninety-five percent (95%) for leave of absence payments to be allowed. (7-1-06)T

02. Time Limits. Payments for periods of temporary absence from long term care facilities will be made for therapeutic home visits for nursing facility residents of up to three (3) days per visit and not to exceed a total of fifteen (15) days per calendar year so long as the days are part of a treatment plan ordered by the attending physician. (7-1-06)T

03. Limits on Amount of Payments. Payment for reserve bed days will be the *lesser*

of the following: ~~(7-1-06)T~~(7-1-06)T

i. Seventy-five percent (75%) of the audited allowable costs of the facility; or (7-1-06)T

ii. The rate charged to private paying patients for reserve bed days. (7-1-06)T

04. Payment Procedures. Each long term care facility must submit its claims to the Department in accordance with the procedures established by the Department. The Department will not pay for a claim on behalf of a medical assistance participant unless the information on the claim is consistent with the information in the Department's computer eligibility file. (7-1-06)T

293. -- 294. (RESERVED).

295. NURSING FACILITY - UTILIZATION CONTROL REVIEWS.
Selection of participants to be reviewed at least annually: (7-1-06)T

01. Level II Participants. Participants who have a Level II evaluation, with the review completed within the quarter of the admission anniversary date; and (7-1-06)T

02. Special Medicaid Rate. Participants who are receiving services that require a special Medicaid rate; and (7-1-06)T

03. Selected Recertification. Participants identified during previous reviews whose improvement may remove the need for continuing nursing facility care. (7-1-06)T

296. NURSING FACILITY - QUALITY INCENTIVES.
Nursing facility providers that are recognized for providing high quality care, based on determinations by the agency of the Department that inspects and certifies such facilities for participation in the Medicaid program, will be eligible for incentive payments. The amount of such payments and the basis therefore will be determined by the Director and will be paid in addition to any other payments for which the facility is eligible under other provisions of this chapter, including provisions related to limitations related to customary charges. However, such payments will be subject to available State and federal funds and will be postponed or omitted in the event that such payments along with other payments made to Nursing Facilities under this chapter would, in aggregate, exceed the estimated payments that would be made utilizing Medicare principles of cost reimbursement. (7-1-06)T

297. -- 299. (RESERVED).

300. 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. (7-1-06)T

301. (RESERVED).

302. PERSONAL CARE SERVICES - ELIGIBILITY.

01. Financial Eligibility. The participant must be financially eligible for medical assistance under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (7-1-06)T

02. Other Eligibility Requirements. Regional Medicaid Services (RMS) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (7-1-06)T

a. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS. (7-1-06)T

b. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed. A UAI is not to be completed for a child participant; (7-1-06)T

c. The RMS reviews the documentation for medical necessity; (7-1-06)T

d. The participant has a plan of care; and (7-1-06)T

e. Services are ordered by a physician or authorized provider. (7-1-06)T

03. State Plan Option. A participant who receives medical assistance is eligible for PCS under the State Medicaid Plan option if the Department finds he requires PCS due to a medical condition that impairs his physical or mental function or independence. (7-1-06)T

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. (7-1-06)T

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." RMS must make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QMRP, or the physician or authorized provider. (7-1-06)T

b. The medical redetermination must assess the following factors: (7-1-06)T

i. The participant's continued need for PCS; (7-1-06)T

ii. Discharge from PCS; and (7-1-06)T

iii. Referral of the participant from PCS to a nursing facility. (7-1-06)T

303. PERSONAL CARE SERVICES (PCS) - COVERAGE AND LIMITATIONS.

01. Medical Care and Services. PCS services include medically-oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence. The provider must deliver at least one (1) of the following services: (7-1-06)T

a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; (7-1-06)T

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; (7-1-06)T

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; (7-1-06)T

d. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (7-1-06)T

e. The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the developmentally disabled participant; (7-1-06)T

f. Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met: (7-1-06)T

i. The task is not complex and can be safely performed in the given participant care situation; (7-1-06)T

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; (7-1-06)T

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; (7-1-06)T

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN; (7-1-06)T

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 (7-1-06)T

vi. Routine medication may be given by the personal assistant through the non-nasogastric tube if authorized by the supervising RN. (7-1-06)T

02. Non-Medical Care and Services. PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed in Subsections 303.01.a. through 303.01.f. of this rule, the provider may also perform the following services: (7-1-06)T

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. (7-1-06)T

b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment. (7-1-06)T

c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant. (7-1-06)T

03. Place of Service Delivery. PCS may be provided only in the participant's own home or personal residence. The participant's personal residence may be a Certified Family Home or a Residential Care or Assisted Living Facility. The following living situations are specifically excluded as a personal residence: (7-1-06)T

a. Certified nursing facilities or hospitals. (7-1-06)T

b. Licensed Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). (7-1-06)T

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.” (7-1-06)T

04. Type of Service Limitations. The provider is excluded from delivering the following services: (7-1-06)T

a. Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; (7-1-06)T

b. Insertion or sterile irrigation of catheters; (7-1-06)T

c. Injecting fluids into the veins, muscles or skin; and (7-1-06)T

d. Administering medication. (7-1-06)T

05. Participant Service Limitations. (7-1-06)T

a. Adults who receive PCS under the State Medicaid Plan option are limited to a maximum of sixteen (16) hours per week per participant. (7-1-06)T

b. Children who meet the necessity criteria for EPSDT services under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Section 882, may receive up to twenty-four (24) hours per day of PCS per child through the month of their twenty-first birthday. (7-1-06)T

06. Provider Coverage Limitations. (7-1-06)T

a. The provider must not bill for more time than was actually spent in service delivery. (7-1-06)T

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. (7-1-06)T

304. PERSONAL CARE SERVICES - PROCEDURAL REQUIREMENTS.

01. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." The Personal Assistance Agency and the participant who lives in his own home are responsible to prepare the plan of care. (7-1-06)T

a. The plan of care for participants who live in their own homes is based on: (7-1-06)T

i. The physician's or authorized provider's information; (7-1-06)T

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 (7-1-06)T

iii. Information obtained from the participant. (7-1-06)T

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. (7-1-06)T

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. (7-1-06)T

02. Service Supervision. The delivery of PCS may be overseen by a licensed professional nurse (RN) or Qualified Mental Retardation Provider (QMRP). The RMS must identify the need for supervision. (7-1-06)T

a. Oversight must include all of the following: (7-1-06)T

i. Assistance in the development of the written plan of care; (7-1-06)T

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (7-1-06)T

iii. Reevaluation of the plan of care as necessary; and (7-1-06)T

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. (7-1-06)T

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: (7-1-06)T

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; (7-1-06)T

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; (7-1-06)T

iii. Reevaluation of the plan of care as necessary, but at least annually; and (7-1-06)T

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. (7-1-06)T

03. PCS Record Requirements for a Participant in His Own Home. The PCS records must be maintained on all participants who receive PCS in their own homes. (7-1-06)T

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: (7-1-06)T

i. Date and time of visit; (7-1-06)T

ii. Length of visit; (7-1-06)T

iii. Services provided during the visit; and (7-1-06)T

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (7-1-06)T

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. (7-1-06)T

c. A copy of the information required in Subsection 304.03 of these rules must be maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. (7-1-06)T

d. Telephone Tracking System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsection 304.03 of these rules. (7-1-06)T

e. Participant in a Residential or Assisted Living Facility. The PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22. "Residential Care or Assisted Living Facilities in Idaho." (7-1-06)T

f. Participant in a Certified Family Home. The PCs record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (7-1-06)T

04. 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. (7-1-06)T

305. PERSONAL CARE SERVICES - PROVIDER QUALIFICATIONS.

01. Provider Qualifications for Personal Assistants. All personal assistants must have at least one (1) of the following qualifications: (7-1-06)T

a. Licensed Professional Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a licensed professional nurse; (7-1-06)T

b. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (7-1-06)T

c. 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. (7-1-06)T

02. Provider Training Requirements. 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: (7-1-06)T

a. Completed one (1) of the Department-approved developmental disabilities training courses; or (7-1-06)T

b. Experience providing direct services to people with developmental disabilities.

(7-1-06)T

c. RMS determines whether developmental disability training is required. Providers who are qualified as QMRPs are exempted from the Department-approved developmental disabilities training course. (7-1-06)T

d. 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: (7-1-06)T

i. The RMS verifies that there are no other qualified providers available; (7-1-06)T

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 (7-1-06)T

iii. The supervising QMRP makes monthly visits until the provider graduates from the training program. (7-1-06)T

03. Provider Exclusion. 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. (7-1-06)T

04. Care Delivered in Provider's Home for a Child. 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. (7-1-06)T

05. Care Delivered in Provider's Home for an Adult. 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." (7-1-06)T

06. 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." (7-1-06)T

07. 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. (7-1-06)T

306. PERSONAL ASSISTANCE AGENCY (PAA) - QUALIFICATIONS AND DUTIES.

01. Provider Agreement Required. A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-Personal Assistance Agencies, Aged and Disabled Waiver Provider Agreement with the Department. The PAA agrees to comply with all conditions within the agreements. A Personal Assistance Agency may also provide fiscal intermediary services as defined in Section 329 of these rules. Each Personal Assistance Agency must direct, control, and monitor the work of each of its personal assistants. (7-1-06)T

02. Responsibilities of a Personal Assistance Agency. A Personal Assistance Agency must be capable of and is responsible for all of the following, no matter how the PAA is organized or the form of the business entity it has chosen: (7-1-06)T

a. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; (7-1-06)T

b. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; (7-1-06)T

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; (7-1-06)T

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; (7-1-06)T

e. Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; (7-1-06)T

f. Assuring that all personal assistants meet the qualifications in Subsection 305.01 of these rules; (7-1-06)T

g. Billing Medicaid for services approved and authorized by the RMS; (7-1-06)T

h. Making referrals for PCS-eligible participants for service coordination as described in Sections 720 through 779 of these rules when a need for the service is identified. (7-1-06)T

307. PERSONAL CARE SERVICES - ~~*PAYMENT METHODOLOGY*~~ *PROVIDER REIMBURSEMENT*.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department ~~*pursuant*~~ *on an annual basis according* to Section 39-5606, Idaho Code~~*, on an annual basis*~~. Provider claims for payment will

be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. ~~(7-1-06)T~~(7-1-06)T

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMS under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.07 of these rules. (7-1-06)T

03. Weighted Average Hourly Rates. Annually Medicaid will conduct a poll of all Idaho nursing facilities and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used for the reimbursement rate to be effective on July 1st of that year. (7-1-06)T

04. Payment Levels for PAA. Medicaid will then establish payment levels for personal assistance agencies for personal assistance services as follows: (7-1-06)T

a. Weekly service needs of zero to sixteen (0-16) hours under the State Medicaid Plan, or a HCBS waiver:

Personal Assistance Agencies	WAHR x 1.55	=	$ amount/hour

(7-1-06)T

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

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

(7-1-06)T

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

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

(7-1-06)T

05. Payment Levels for Adults in Residential Care or Assisted Living Facilities or

Certified Family Homes. Adult participants living in Residential Care or Assisted Living Facilities (RCALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (7-1-06)T

a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (7-1-06)T

b. Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (7-1-06)T

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (7-1-06)T

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, mental retardation, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, mental retardation, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c of these rules. (7-1-06)T

06. Attending Physician Reimbursement Level. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (7-1-06)T

07. Supervisory RN and QMRP Reimbursement Level. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMS. (7-1-06)T

a. The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMS. (7-1-06)T

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMS. (7-1-06)T

308. PERSONAL CARE SERVICES (PCS) - QUALITY ASSURANCE.

01. Responsibility for Quality. Personal Assistance Agencies are responsible for assuring that they provide quality services in compliance with applicable rules. (7-1-06)T

02. Review Results. 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. (7-1-06)T

03. Quality Improvement Plan. 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. (7-1-06)T

309. -- 319. (RESERVED).

320. AGED OR DISABLED WAIVER SERVICES.
Idaho's elderly and physically disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the consumer's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others. (7-1-06)T

321. AGED OR DISABLED WAIVER SERVICES - DEFINITIONS.
The following definitions apply to Sections 320 through 330 of these rules: (7-1-06)T

01. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities. (7-1-06)T

02. Fiscal Intermediary Services. Services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (7-1-06)T

03. Individual Service Plan. A document which outlines all services including, but not limited to, personal assistance services and instrumental activities of daily living (IADL), required to maintain the individual in his home and community. The plan is initially developed by the RMS or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the RMS and all Medicaid reimbursable services must be contained in the plan. (7-1-06)T

04. Personal Assistance Agency or Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for the care given, and provides payroll, including all required withholding for federal and state tax purposes, and benefits for care providers working for them. They also bill Medicaid for services provided by employees, and collect participant contribution. (7-1-06)T

05. Employer of Record. An entity which bills for services, withholds required taxes, and conducts other administrative activities for a waiver program participant. Such an entity is also called a personal assistance agency functioning as a fiscal intermediary. (7-1-06)T

06. Employer of Fact. A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver program provider. This individual may be a family member. (7-1-06)T

07. Participant. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program. (7-1-06)T

322. AGED OR DISABLED WAIVER SERVICES - ELIGIBILITY.
The Department provides waiver services to eligible 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 participant to be eligible, the Department must find that the participant: (7-1-06)T

01. Has a Disabling Condition. Requires services due to a disabling condition which impairs their mental or physical function or independence; and (7-1-06)T

02. Safe in a Non-Institutional Setting. Be capable of being maintained safely and effectively in a non-institutional setting; and (7-1-06)T

03. Requires Such Services. Would, in the absence of such services, require the level of care provided in a Nursing Facility under Sections 222 and 223 of these rules. (7-1-06)T

323. AGED OR DISABLED WAIVER SERVICES - PARTICIPANT ELIGIBILITY DETERMINATION.

Waiver eligibility will be determined by the RMS. The participant must be eligible for Medicaid as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." In addition, waiver participants must meet the following requirements. (7-1-06)T

01. Requirements for Determining Participant Eligibility. The RMS must determine that: (7-1-06)T

a. The participant would qualify for nursing facility level of care under Sections 222 and 223 of these rules**,** if the waiver services listed in Section 326 of these rules were not made available; and (7-1-06)T

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must be made by the RMS. Prior to any denial of services on this basis, the Department must verify that services to correct the concerns of the team are not available. (7-1-06)T

c. The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of nursing facility care. (7-1-06)T

d. Following the approval by the RMS for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (7-1-06)T

02. Admission to a Nursing Facility. A participant who is determined by the RMS to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to a nursing facility. (7-1-06)T

03. Redetermination Process. Case Redetermination will be conducted by the RMS or its contractor. The redetermination process will verify that the participant continues to meet

nursing facility level of care and the participant's continued need for waiver services. (7-1-06)T

324. AGED OR DISABLED WAIVER SERVICES - TARGET GROUP.
Persons who would be Medicaid eligible if residing in a nursing facility, require the level of care provided in a nursing facility, are over the age of eighteen (18), demonstrate significant disability on the Uniform Assessment Instrument (UAI), and have deficits which affect their ability to function independently. (7-1-06)T

325. HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER - PARTICIPANT LIMITATIONS.
The number of Medicaid participants to receive waiver services under the Home and Community Based Services (HCBS) waiver for the aged and disabled will be limited to the projected number of users identified in the Department's approved waiver. If necessary, participants who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th of each new waiver year. The earliest effective date of waiver service delivery for these participants will be October 1st of each new waiver year. (7-1-06)T

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

01. Adult Day Care. Adult day care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (7-1-06)T

02. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that includes: (7-1-06)T

a. Medication management; (7-1-06)T

b. Assistance with activities of daily living; (7-1-06)T

c. Meals, including special diets; (7-1-06)T

d. Housekeeping; (7-1-06)T

e. Laundry; (7-1-06)T

f. Transportation; (7-1-06)T

g. Opportunities for socialization; (7-1-06)T

h. Recreation; and (7-1-06)T

i. Assistance with personal finances. (7-1-06)T

j. Administrative oversight must be provided for all services provided or available in this setting. (7-1-06)T

k. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (7-1-06)T

03. Assistive Technology. Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. (7-1-06)T

04. Assisted Transportation. Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (7-1-06)T

a. Assisted transportation service is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 860 through 876, and will not replace it. (7-1-06)T

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (7-1-06)T

05. Attendant Care. Attendant care services are those services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include, but are not limited to personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Services may occur in the participant's home, community, work, school or recreational settings. (7-1-06)T

a. To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized. (7-1-06)T

b. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (7-1-06)T

06. Chore services. Chore services include the services provided in Subsection 326.06.a and b of this rule: (7-1-06)T

a. Intermittent Assistance may include the following. (7-1-06)T

i. Yard maintenance; (7-1-06)T

ii. Minor home repair; (7-1-06)T

iii. Heavy housework; (7-1-06)T

iv. Sidewalk maintenance; and (7-1-06)T

v. Trash removal to assist the participant to remain in their home. (7-1-06)T

b. Chore activities may include the following: (7-1-06)T

i. Washing windows; (7-1-06)T

ii. Moving heavy furniture; (7-1-06)T

iii. Shoveling snow to provide safe access inside and outside the home; (7-1-06)T

iv. Chopping wood when wood is the participant's primary source of heat; and (7-1-06)T

v. Tacking down loose rugs and flooring. (7-1-06)T

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payer is willing to or is responsible for their provision. (7-1-06)T

d. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (7-1-06)T

07. Adult Companion. In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (7-1-06)T

08. Consultation. Consultation services are services to a participant or family member. Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (7-1-06)T

09. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: (7-1-06)T

a. Rent or own their own home; (7-1-06)T

b. Are alone for significant parts of the day; (7-1-06)T

c. Have no regular caretaker for extended periods of time; and (7-1-06)T

d. Are unable to prepare a balanced meal. (7-1-06)T

10. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (7-1-06)T

11. Home Modifications. Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization. Such adaptations may include: (7-1-06)T

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (7-1-06)T

b. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (7-1-06)T

c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (7-1-06)T

12. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who: (7-1-06)T

a. Rent or own their home, or live with unpaid relatives; (7-1-06)T

b. Are alone for significant parts of the day; (7-1-06)T

c. Have no caretaker for extended periods of time; and (7-1-06)T

d. Would otherwise require extensive routine supervision. (7-1-06)T

13. Psychiatric Consultation. Psychiatric Consultation is direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (7-1-06)T

14. Respite Care. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (7-1-06)T

15. Service Coordination. Service coordination includes all of the activities contained in Section 727 of these rules. Such services are designed to foster independence of the participant, and will be time limited. (7-1-06)T

a. All services will be provided in accordance with an individual service plan. All services will be incorporated into the Individual Service plan and authorized by the RMS. (7-1-06)T

b. The service coordinator must notify the RMS, the Personal Assistance Agency, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition. (7-1-06)T

16. Skilled Nursing Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit.Nursing services may include but are not limited to: (7-1-06)T

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (7-1-06)T

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (7-1-06)T

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (7-1-06)T

d. Injections; (7-1-06)T

e. Blood glucose monitoring; and (7-1-06)T

f. Blood pressure monitoring. (7-1-06)T

327. AGED OR DISABLED WAIVER SERVICES - PLACE OF SERVICE DELIVERY.

01. Place of Service Delivery. Waiver services may be provided in the participant's: (7-1-06)T

a. Personal residence; (7-1-06)T

b. Employment program; or (7-1-06)T

c. Community. (7-1-06)T

02. Excluded Living Situations. Living situations specifically excluded as a personal residence are: (7-1-06)T

a. Skilled, or Intermediate Care Facilities; (7-1-06)T

b. Nursing Facility; (7-1-06)T

c. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (7-1-06)T

d. Hospitals. (7-1-06)T

328. AGED OR DISABLED WAIVER SERVICES - PROCEDURAL REQUIREMENTS.

01. Role Of The Regional Medicaid Services. The RMS will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by RMS staff or a contractor. The RMS will review and approve all individual service plans, and the will authorize Medicaid payment by type, scope, and amount. (7-1-06)T

a. Services which are not in the individual service plan approved by the RMS are not eligible for Medicaid payment. (7-1-06)T

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (7-1-06)T

c. The earliest date that services may be approved by the RMS for Medicaid payment is the date that the participant's individual service plan is signed by the participant or his designee. (7-1-06)T

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (7-1-06)T

a. The UAI; (7-1-06)T

b. The individual service plan developed by the Department or its contractor; and (7-1-06)T

c. Any other medical information which verifies the need for nursing facility services in the absence of the waiver services. (7-1-06)T

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the RMS or its contractor. (7-1-06)T

04. Service Delivered Following A Written Individual Service Plan. All waiver

services must be authorized by the RMS in the Region where the participant will be residing and services provided based on a written individual service plan. (7-1-06)T

a. The initial individual service plan is developed by the RMS or its contractor, based on the UAI, in conjunction with: (7-1-06)T

i. The waiver participant (with efforts made by the RMS to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); and (7-1-06)T

ii. The guardian, when appropriate; and (7-1-06)T

iii. The supervising nurse or case manager, when appropriate; and (7-1-06)T

iv. Others identified by the waiver participant. (7-1-06)T

b. The individual service plan must include the following: (7-1-06)T

i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; and (7-1-06)T

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; and (7-1-06)T

iii. The providers of waiver services when known; and (7-1-06)T

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (7-1-06)T

v. The signature of the participant or his legal representative, agreeing to the plan. (7-1-06)T

c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (7-1-06)T

d. All services reimbursed under the Aged or Disabled Waiver must be authorized by the RMS prior to the payment of services. (7-1-06)T

e. The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the RMS or its contractor. (7-1-06)T

05. Provider Records. Records will be maintained on each waiver participant. (7-1-06)T

a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-06)T

i. Date and time of visit; (7-1-06)T

ii. Services provided during the visit; (7-1-06)T

iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (7-1-06)T

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the RMS or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (7-1-06)T

b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the RMS. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (7-1-06)T

c. The individual service plan initiated by the RMS or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the RMS to each individual service provider with a release of information signed by the participant or legal representative. (7-1-06)T

06. Provider Responsibility For Notification. The service provider is responsible to notify the RMS, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (7-1-06)T

07. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (7-1-06)T

08. Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date which services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. (7-1-06)T

329. AGED OR DISABLED WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

Each provider must have a signed provider agreement with the Department for each of the services it provides. (7-1-06)T

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations where no agency exists, or no fiscal intermediary is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by an agency or fiscal intermediary is still not available. (7-1-06)T

02. Personal Assistance Agency That Provides Fiscal Intermediary Services. A personal assistance agency that focuses on fostering participant independence and personal control of services delivered. The core tasks are: (7-1-06)T

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (7-1-06)T

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (7-1-06)T

c. To bill the Medicaid program for services approved and authorized by the Department; (7-1-06)T

d. To collect any participant participation due; (7-1-06)T

e. To pay personal assistants and other waiver service providers for service; (7-1-06)T

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (7-1-06)T

g. To offer a full range of services and perform all services contained in a written agreement between the participant and the provider; (7-1-06)T

h. Make referrals for PCS eligible participant for service coordination when a need for such services is identified; and (7-1-06)T

i. Obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (7-1-06)T

03. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. (7-1-06)T

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (7-1-06)T

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (7-1-06)T

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (7-1-06)T

05. Nursing Service Provider Qualifications. Nursing Service Providers must be

licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (7-1-06)T

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (7-1-06)T

a. A master's degree in a behavioral science; (7-1-06)T

b. Be licensed in accordance with state law and regulations; or (7-1-06)T

c. Have a bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (7-1-06)T

07. Service Coordination. Service coordinators and service coordination agencies must meet the requirements specified in Section 729 of these rules unless specifically modified by another section of these rules. (7-1-06)T

08. Consultation Services. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (7-1-06)T

09. Adult Residential Care Providers. Adult Residential Care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are is provided to meet the needs of the participants accepted for admission. (7-1-06)T

10. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (7-1-06)T

a. Supervising the direct service; (7-1-06)T

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (7-1-06)T

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (7-1-06)T

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (7-1-06)T

e. Being inspected and licensed as a food establishment by the district health department. (7-1-06)T

11. Personal Emergency Response Systems. Providers must demonstrate that the devices installed in waiver participant's homes meet Federal Communications Standards, Underwriter's Laboratory Standards, or equivalent standards. (7-1-06)T

12. Adult Day Care. Facilities which provide adult day care must be maintained in safe and sanitary manner. (7-1-06)T

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (7-1-06)T

b. Providers accepting participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. (7-1-06)T

13. Assistive Technology. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (7-1-06)T

14. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications. (7-1-06)T

15. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. (7-1-06)T

16. Homemaker Services. The homemaker must be an employee of record or fact of an agency. (7-1-06)T

17. Home Modifications. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (7-1-06)T

330. AGED OR DISABLED WAIVER SERVICES - ~~*PAYMENT METHODOLOGY*~~ *PROVIDER REIMBURSEMENT*.
The criteria used in reimbursing providers for waiver services are listed in Subsections 330.01 through 330.03 of these rules. (7-1-06)T

01. Fee for Services. Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. Adult residential care will be paid on a per diem basis, based on the number of hours and types of assistance required by the participant as identified in the UAI. (7-1-06)T

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's payment system contractor. (7-1-06)T

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 participant's home or other service delivery location when the participant is not being provided waiver or state plan transportation. (7-1-06)T

331. - 334. RESERVED.

335. TRAUMATIC BRAIN INJURY (TBI) WAIVER SERVICES.
Pursuant to 42 CFR Section 435.217, it is the intention of the Department to provide waiver services to eligible 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 participant to be eligible, the Department must find that the 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 nursing facility under Sections 222 and 226 of these rules. (7-1-06)T

336. (RESERVED).

337. TBI WAIVER SERVICES - ELIGIBILITY.
Persons who are Medicaid eligible, whose injury to the brain occurred on or after the age of twenty-two (22) and have been diagnosed with a traumatically acquired non-degenerative, structural brain injury resulting in residual deficits and disability who require the level of care provided in a nursing facility. (7-1-06)T

01. 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 in the table below:

TABLE 337	
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

(7-1-06)T

338. TBI WAIVER SERVICES - ELIGIBILITY DETERMINATION.
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 medical assistance eligibility requirements as described in IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)," Section 787. In addition, waiver participants must meet the following requirements: (7-1-06)T

01. Requirements for Determining Participant Eligibility. The Regional Medicaid Services must determine that: (7-1-06)T

a. The participant would qualify for nursing facility level of care as set forth in Sections 222 and 226 of these rules if the waiver services listed in Section 340 of these rules were not made available; (7-1-06)T

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by the Department's Case Manager, with input from the 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; and (7-1-06)T

c. The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of nursing facility care and other medical costs. Individual 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 nursing facility 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. (7-1-06)T

d. Following the approval by the Regional Medicaid Services for services under the waiver, the participants must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (7-1-06)T

02. Admission to a Nursing Facility. A participant who is determined by the Regional Medicaid 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 a nursing facility. (7-1-06)T

03. Self Reliance Specialist. The 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 nursing facility except that the self reliance specialist will forward potentially eligible applications immediately to the Regional Medicaid Services for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (7-1-06)T

04. Redetermination Process. Case Redetermination. (7-1-06)T

a. Financial redetermination will be conducted pursuant to 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 Services, or sooner at the request of the 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. (7-1-06)T

b. The redetermination process will assess the following factors: (7-1-06)T

i. The participant's continued need for waiver services; and (7-1-06)T

ii. Discharge from the waiver services program. (7-1-06)T

339. HOME AND COMMUNITY-BASED WAIVER PARTICIPANT LIMITATIONS.
The number of Medicaid participants to receive waiver services under the home and community based waiver for 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 30th of each new waiver year. The earliest effective date of waiver service delivery for these participants will be October 1st of each new waiver year. (7-1-06)T

340. TBI WAIVER SERVICES - COVERAGE AND LIMITATIONS.
Services that may be provided under the waiver consist of residential habilitation, chore, respite care, supported employment, transportation, environmental accessibility adaptations, specialized medical equipment and supplies, personal emergency response system, day rehabilitation, home delivered meals, behavior consultation/crisis management, and skilled nursing services. Also included are extended state plan services including administrative case management, physical therapy, occupational therapy, speech therapy, personal care services. (7-1-06)T

01. Residential Habilitation. Services consist of an integrated array of individually-tailored services and supports furnished to eligible 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 Subsections 340.02 and 340.03 of these rules. (7-1-06)T

02. 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: (7-1-06)T

a. 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; (7-1-06)T

b. Money Management. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations;

(7-1-06)T

c. 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; (7-1-06)T

d. Socialization. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities which are merely diversional or recreational in nature; (7-1-06)T

e. 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; or (7-1-06)T

f. 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. (7-1-06)T

03. Personal Assistance Services. Services consist of assisting the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (7-1-06)T

04. Personal Assistance Services Skills Training. Skills training consists of teaching waiver participants, family members, alternative family caregiver, or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skill training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (7-1-06)T

05. 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 participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services

provided in a home rented or owned by the participant. (7-1-06)T

06. Respite Care Services. Services consist of those services provided, on a short term basis, in the home of either the waiver 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 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 participants who reside with non-paid caregivers. (7-1-06)T

07. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; 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. (7-1-06)T

08. Exclusions From Supported Employment. (7-1-06)T

a. 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. (7-1-06)T

b. 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 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. (7-1-06)T

09. Transportation Services. Services consist of services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the 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 will 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. (7-1-06)T

10. Environmental Accessibility Adaptations. Adaptations consist of interior or exterior physical adaptations to the home, required by the waiver 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 participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies

necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (7-1-06)T

11. Specialized Medical Equipment and Supplies. Specialized medical equipment and supplies consist of devices, controls, or appliances, specified in the Plan of Care which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds will be in addition to any medical equipment and supplies furnished under the State Plan and will exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (7-1-06)T

12. Personal Emergency Response Systems (PERS). PERS may be provided to monitor waiver participant safety and provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (7-1-06)T

13. Home Delivered Meals. Home delivered meals consist of meals designed to promote adequate waiver participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day, and who have no regular caretaker for extended periods of time. (7-1-06)T

14. Extended State Plan Services. Extended State 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 Plan. Under the waiver, therapy services will include: (7-1-06)T

a. Services provided in the waiver participant's residence, day rehabilitation site, or supported employment site; (7-1-06)T

b. Consultation with other service providers and family members; (7-1-06)T

c. Participation on the participant's Plan of Care team. (7-1-06)T

15. 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 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 or nutritional supplements which are to be administered on a continuous or daily basis, injections, blood glucose monitoring, and blood pressure monitoring. (7-1-06)T

16. Personal Care Services. Services consist of assistance due to a medical condition which impairs physical or mental function and which maintains a participant safely and effectively in 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. (7-1-06)T

17. Behavior Consultation or Crisis Management. Behavior consultation or crisis management consist of services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (7-1-06)T

18. 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 participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in a participant's Plan of Care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical, occupational, or speech therapies listed in the Plan of Care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (7-1-06)T

19. Place of Service Delivery. Waiver services for participants with a traumatic brain injury may be provided in the participant's personal residence, 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: (7-1-06)T

a. Excluded as a Personal Residence. (7-1-06)T

i. Licensed Skilled, or Intermediate Care Facilities, Certified Nursing Facility (NF) or hospital; and (7-1-06)T

ii. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and (7-1-06)T

iii. Residential Care or Assisted Living Facility. (7-1-06)T

b. Additional Service Limitations. Additional limitations to specific services are listed under that service definition. (7-1-06)T

341. TBI WAIVER SERVICES - PROCEDURAL REQUIREMENTS.

01. Service Delivered Following A Written Plan of Care. All waiver services must be authorized by the Regional Medicaid Services in the region where the participant will be residing and provided based on a written Plan of Care. (7-1-06)T

a. Development of the Plan of Care. The Plan of Care is developed by the Plan of Care team which includes: (7-1-06)T

i. The Waiver Participant. Efforts must be made to maximize the participant's participation on the team by providing him with information and education regarding his rights; and (7-1-06)T

ii. The Department's administrative case manager; and (7-1-06)T

iii. The guardian when appropriate; and (7-1-06)T

iv. May include others identified by the waiver participant. (7-1-06)T

b. Assessment Process Approved by the Department. The Plan of Care must be based on an assessment process approved by the Department. (7-1-06)T

c. Included in the Plan of Care. The Plan of Care must include the following: (7-1-06)T

i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; and (7-1-06)T

ii. Supports and service needs that are to be met by the participant's family, friends and other community services; and (7-1-06)T

iii. The providers of waiver services when known; and (7-1-06)T

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (7-1-06)T

v. The signature of the participant or his legal representative and the case manager. (7-1-06)T

vi. The plan must be revised and updated by the Plan of Care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (7-1-06)T

d. Authorization of Services. All services reimbursed under the Home and

Community Based Waiver for participants with a traumatic brain injury must be authorized prior to the payment of services by the Regional Medicaid Services. (7-1-06)T

e. Service Supervision. The Plan of Care which includes all waiver services is monitored by the Department's case manager. (7-1-06)T

02. Provider Records. Three (3) types of record information will be maintained on all participants receiving waiver services: (7-1-06)T

a. Service Provider Information. Direct Service Provider Information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-06)T

i. Date and time of visit; and (7-1-06)T

ii. Services provided during the visit; and (7-1-06)T

iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (7-1-06)T

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Case manager to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (7-1-06)T

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Regional Medicaid Services. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (7-1-06)T

b. Plan of Care. The Plan of Care which is initiated by the Regional Medicaid Services and developed by the case manager and the Plan of Care team must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 341.01 of these rules and a copy of the most current Plan of Care will be maintained in the participant's home and will be available to all service providers and the Department. (7-1-06)T

c. Verification of Services Provided. In addition to the Plan of Care, at least monthly the case manager will verify in writing that the services provided were consistent with the Plan of Care. Any changes in the plan will be documented and include the signature of the case manager and when possible, the participant. (7-1-06)T

03. Records Maintenance. In order to provide continuity of services, when a participant is transferred among service providers, or when a participant changes case managers, all of the foregoing participant records will be delivered to and held by the Regional Medicaid Services until a replacement service provider or case manager assumes the case. When a participant leaves the waiver services program, the records will be retained by the Regional Medicaid Services as part of the participant's closed case record. Provider agencies will be

responsible to retain their participant's records for three (3) years following the date of service. (7-1-06)T

04. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the case manager when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (7-1-06)T

342. TBI WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES. All providers of waiver services must have a valid provider agreement or performance contract with the Department. Performance under this agreement or contract will be monitored by the Regional Medicaid Services in each region. (7-1-06)T

01. Residential Habilitation Service Providers. Providers of residential habilitation services must meet the following requirements: (7-1-06)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 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 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. (7-1-06)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 participant. Skill training may be provided by a Program Coordinator, if no agency is available in their geographic area as outlined in Subsection 342.01.c of these rules, who has demonstrated experience in writing skill training programs. Additional training requirements may also include: 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. (7-1-06)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 service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (7-1-06)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 certified family home.

Non-compliance with the above standards will be cause for termination of the provider's provider agreement/contract. (7-1-06)T

02. Chore Service Providers. Providers of chore services must meet the following minimum qualifications: (7-1-06)T

a. Be skilled in the type of service to be provided; and (7-1-06)T

b. Demonstrate the ability to provide services according to a Plan of Care (7-1-06)T

03. Respite Care Service Providers. Providers of respite care services must meet the following minimum qualifications: (7-1-06)T

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 or the family or guardian; (7-1-06)T

b. Have received care giving instructions in the needs of the person who will be provided the service; (7-1-06)T

c. Demonstrate the ability to provide services according to a Plan of Care; (7-1-06)T

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (7-1-06)T

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; (7-1-06)T

f. Be free of communicable diseases; and (7-1-06)T

g. Have successfully completed a traumatic brain injury training course approved by the Department. (7-1-06)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 traumatic brain injury training course approved by the Department. (7-1-06)T

05. Transportation Service Providers.Transportation service providers must: (7-1-06)T

a. Possess a valid driver's license; and (7-1-06)T

b. Possess valid vehicle insurance. (7-1-06)T

06. Environmental Modifications Service Providers. Environmental Modifications services must: (7-1-06)T

a. Be done under a permit, if required; and (7-1-06)T

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (7-1-06)T

07. Specialized Medical Equipment and Supplies. Specialized Medical Equipment and Supplies purchased under this service must: (7-1-06)T

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (7-1-06)T

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. (7-1-06)T

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. (7-1-06)T

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: (7-1-06)T

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; (7-1-06)T

b. Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes; (7-1-06)T

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; (7-1-06)T

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; (7-1-06)T

e. Provide documentation of current driver's license for each driver; and (7-1-06)T

f. Must be inspected and licensed as a food establishment by the District Health Department. (7-1-06)T

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 traumatic brain injury training course approved by the Department. (7-1-06)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 traumatic brain injury training course approved by the Department. (7-1-06)T

12. Behavior Consultation or Crisis Management Service Providers. Behavior Consultation or Crisis Management Providers must meet the following: (7-1-06)T

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; or (7-1-06)T

b. Be a licensed pharmacist; or (7-1-06)T

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(7-1-06)T

d. Take a traumatic brain injury training course approved by the Department. (7-1-06)T

e. Emergency back-up providers must also meet the minimum provider qualifications under Residential Habilitation services. (7-1-06)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 traumatic brain injury course approved by the Department. (7-1-06)T

14. Personal Care Service Providers. Personal Care Service providers must meet the requirements outlined in Section 305 of these rules for PCS Provider Qualifications. Providers must take a traumatic brain injury training course approved by the Department. (7-1-06)T

343. TBI WAIVER SERVICES - PAYMENT METHODOLOGY.
The following outlines the criteria used in reimbursing providers for waiver services. (7-1-06)T

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. (7-1-06)T

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. (7-1-06)T

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 participant's home or other service delivery location when the participant is not being provided transportation. (7-1-06)T

344. -- 449. (RESERVED).

SUB AREA: HOSPICE
(Sections 450 Through 459)

450. HOSPICE.
Medical assistance will provide payment for hospice services for eligible participants. Reimbursement will be based on Medicare program coverage as set out in Sections 450 through 456 of these rules. (7-1-06)T

451. HOSPICE - DEFINITIONS.
The following definitions apply to Sections 450 though 456 of these rules. (7-1-06)T

01. Attending Physician. A physician who: (7-1-06)T

a. Is a doctor of medicine or osteopathy; and (7-1-06)T

b. Is identified by the participant, at the time he elects to receive hospice care, as having the most significant role in the determination and delivery of the participant's medical care. (7-1-06)T

02. Benefit Period. A period of time that begins on the first day of the month the participant elects hospice and ends on the last day of the eleventh successive calendar month. (7-1-06)T

03. Bereavement Counseling. Counseling services provided to the participant's family after the participant's death. (7-1-06)T

04. Cap Amount. The maximum amount of reimbursement the Idaho Medicaid Program will pay a designated hospice for providing services to Medicaid participants per Subsection 456.04 of these rules. (7-1-06)T

05. Cap Period. The twelve (12) month period beginning November 1 and ending October 31 of the next year. See overall hospice reimbursement cap referred to in Subsection 456.04 of these rules. (7-1-06)T

06. Election Period. One (1) of eight (8) periods within the benefit period which an participant may elect to receive Medicaid coverage of hospice care. Each period consists of any calendar month, or portion thereof, chosen within the benefit period. (7-1-06)T

07. Employee. An individual serving the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization that is appropriately trained and assigned to the hospice unit. Employee also refers to a volunteer under the jurisdiction of the hospice. (7-1-06)T

08. Freestanding Hospice. A hospice that is not part of any other type of participating provider. (7-1-06)T

09. Hospice. A public agency or private organization or a subdivision that: (7-1-06)T

a. Is primarily engaged in providing care to terminally ill participants; and (7-1-06)T

b. Meets the conditions specified for certification for participation in the Medicare and Medicaid programs and has a valid provider agreement. (7-1-06)T

10. Independent Physician. An attending physician who is not an employee of the hospice. (7-1-06)T

11. Representative. A person who is, because of the participant's mental or physical incapacity, legally authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill participant. (7-1-06)T

12. Social Worker. A person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education. (7-1-06)T

13. Terminally Ill. When an participant has a certified medical prognosis that his or her life expectancy is six (6) months or less per Subsection 454.01 of these rules. (7-1-06)T

452. HOSPICE - ELIGIBILITY.
Inherent in the Hospice program is that a participant understands the nature and basis for eligibility for hospice care without an inappropriate and explicit written statement about how the impending death will affect care. Though only written acknowledgment of the election periods is mandated, it is required that the participant or their representative be fully informed by a hospice before the beginning of a participant's care about the reason and nature of hospice care. The following are the eligibility requirements for Hospice: (7-1-06)T

01. Certification. A certification that the participant is terminally ill must have been completed in accordance with Section 454.01 of these rules. (7-1-06)T

02. Medically Necessary. Hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. (7-1-06)T

03. Election of Services.The participant must elect hospice care in accordance with Section 454.02 of these rules**.** (7-1-06)T

453. HOSPICE - COVERAGE REQUIRMENTS AND LIMITATIONS.
The following services are required: (7-1-06)T

01. Nursing Care. Nursing care provided by or under the supervision of a registered nurse. (7-1-06)T

02. Medical Social Services. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. (7-1-06)T

03. Physician Services. Physician's services performed by a physician as defined in Subsection 451.01 of these rules. (7-1-06)T

04. Counseling Services. Counseling services provided to the terminally ill participant and the family members or other persons caring for the participant at home. Counseling, including bereavement and dietary counseling, are core hospice services provided both for the purpose of training the participant's family or other care-giver to provide care, and for the purpose of helping the participant and those caring for him to adjust to the participant's approaching death. (7-1-06)T

05. Inpatient Care. Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital, or a nursing facility that additionally meets the hospice standards regarding staff and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the participant's family or other persons caring for the participant at home. (7-1-06)T

06. Medical Equipment and Supplies. Medical equipment and supplies include drugs and biologicals. Only drugs as defined in Subsection 1861(t) of the Social Security Act and which are used primarily for the relief of pain and symptom control related to the patient's terminal illness are required. Appliances include durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he is under hospice care. Medical supplies include only those that are part of the written plan of care. (7-1-06)T

07. Home Health Services. Home health aide and homemaker services furnished by qualified aides. Home health aides will provide personal care services and will also perform household services necessary to maintain a safe and sanitary environment in areas of the home used by the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services include assistance in maintenance of a safe and healthy environment and services to enable the participant to carry out the plan of care. (7-1-06)T

08. Therapies. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the participant to maintain activities of daily living and basic functional skills. (7-1-06)T

09. Core Services. Nursing care, physician's services, medical social services, and counseling are core hospice services and must be routinely provided by hospice employees. Supplemental core services may be contracted for during periods of peak patient loads and to obtain physician specialty services. (7-1-06)T

454. HOSPICE - PROCEDURAL REQUIREMENTS.

01. Physician Certification. The hospice must obtain the certification that a participant is terminally ill in accordance with the following procedures: (7-1-06)T

a. For the first period of hospice coverage, the hospice must obtain, no later than two (2) calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the participant's attending physician (if the participant has one). The certification must include the statement that the participant's medical prognosis is that his or her life expectancy is six (6) months or less and the signature(s) of the physician(s). In the event the participant's medical prognosis or the appropriateness of hospice care is questionable, the Department has the right to obtain another physician's opinion to verify a participant's medical status. (7-1-06)T

b. For any subsequent election period, the hospice must obtain, no later than two (2) calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the interdisciplinary group. The certification must include the statement that the participant's medical prognosis is that his or her life expectancy is six (6) months or less and the signature(s) of the physician(s). (7-1-06)T

c. The hospice must maintain the monthly certification statements for review. (7-1-06)T

d. The hospice will submit a physician listing with their provider application and update changes in the listing of physicians which are hospice employees, including physician volunteers, to the Bureau of Facility Standards. The designated hospice must also notify the Medicaid program when the designated attending physician of a participant in their care is not a hospice employee. (7-1-06)T

02. Election Procedures. If an participant elects to receive hospice care, he must file an election statement with a particular hospice. An election statement may also be filed by a legal representative or guardian per Section 15-5-312, Idaho Code. (7-1-06)T

a. An election to receive hospice care will be automatically renewed after the initial election period and through any subsequent election periods without a break in care as long as the participant remains in the care of a designated hospice and does not revoke the election. (7-1-06)T

b. A participant who elected less than eight (8) monthly election periods within the benefit period may request the availability of the remaining election periods. When the following conditions are met, the request will be granted. (7-1-06)T

i. The hospice days available did not exceed two hundred ten (210) days in the benefit period due to the loss of financial eligibility. (7-1-06)T

ii. The participant or the legal representative did not change hospices excessively per Subsection 454.05 of these rules. (7-1-06)T

iii. The participant or the legal representative did not revoke hospice election periods more than eight (8) times per Subsection 454.04 of these rules. (7-1-06)T

c. An participant may receive hospice services from the first day of hospice care or any subsequent day of hospice care, but a participant cannot designate an effective date that is

earlier than the date that the election is made. (7-1-06)T

d. A participant must waive all rights to Medicaid payments for the duration of the election period of hospice care, with the following exceptions: (7-1-06)T

i. Hospice care and related services provided either directly or under arrangements by the designated hospice to the participant. (7-1-06)T

ii. Any Medicaid services that are not related or equivalent to the treatment of the terminal condition or a related condition for which hospice care was elected. (7-1-06)T

iii. Physician services provided by the participant's designated attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. (7-1-06)T

03. Election of Hospice. The election statement must include the following items of information: (7-1-06)T

a. Identification of the particular hospice that will provide care to the participant. (7-1-06)T

b. The participant's or representative's acknowledgment that he has been given a full understanding of hospice care. (7-1-06)T

c. The participant's or representative's acknowledgment that he understands that all Medicaid services except those identified in Subsection 454.02.d of these rules, are waived by the election during the hospice benefit period. (7-1-06)T

d. The effective date of the election. (7-1-06)T

e. The signature of the participant or the representative and the date of that signature. (7-1-06)T

04. Revocation of Hospice Election. A participant or representative may revoke the election of hospice care at any time. (7-1-06)T

a. To revoke the election of hospice care, the participant must file a signed statement with the hospice that includes that the participant revokes the election for Medicaid coverage of hospice care effective as of the date of the revocation. (7-1-06)T

b. Upon revocation of the hospice election, other Medicaid coverage is reinstated. (7-1-06)T

05. Change of Hospice. A participant may at any time change their designated hospice during election periods for which he is eligible. (7-1-06)T

a. A participant may change designated hospices no more than six (6) times during the hospice benefit period. (7-1-06)T

b. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the participant must file during the monthly election period, with the hospice from which he has received care and with the newly designated hospice, a dated and signed statement that includes the following information: (7-1-06)T

i. The name of the hospice from which the participant has received care; (7-1-06)T

ii. The name of the hospice from which he plans to receive care; and (7-1-06)T

iii. The effective date of the change in hospices. (7-1-06)T

c. A change in ownership of a hospice is not considered a change in the patient's designation of a hospice, and requires no action on the patient's part. (7-1-06)T

06. Plan of Care. A plan of care must be established and reviewed at least monthly. To be covered, services must be consistent with the plan of care. (7-1-06)T

a. In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one (1) other group member (nurse, physician, medical social worker, or counselor) before writing the initial plan of care. (7-1-06)T

b. At least one (1) of the persons involved in developing the initial plan must be a nurse or a physician. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. (7-1-06)T

c. The other two (2) members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two (2) calendar days following the day of assessment, input may be provided by telephone. (7-1-06)T

455. HOSPICE - PROVIDER QUALIFICATIONS AND DUTIES.
All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the category of the service. (7-1-06)T

456. HOSPICE - ~~*PAYMENT METHODOLOGY*~~ *PROVIDER REIMBURSEMENT*.
With the exception of payment for physician services under Section 458 of these rules, Medicaid reimbursement for hospice care will be made at one (1) of four (4) predetermined rates for each day in which a participant receives the respective type and intensity of the services furnished under the care of the hospice. The four (4) rates are prospective rates; there will be no retroactive rate adjustments other than the application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. A description of the payment for each level of care is described in Subsections 456.01 through 456.04 of these rules. (7-1-06)T

01. Routine Home Care. The hospice will be paid the routine home care rate for each

day the patient is in residence, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. (7-1-06)T

02. Continuous Home Care. Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to twenty-four (24) hours per day. (7-1-06)T

03. Inpatient Respite Care. The hospice will be paid at the inpatient respite care rate for each day that the participant is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days at a time including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate routine, continuous, or general inpatient rate. (7-1-06)T

04. General Inpatient Care. Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the participant receives hospice general inpatient care except as described in Section 458 of these rules. (7-1-06)T

a. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date. (7-1-06)T

b. Hospice payment rates. The Medicaid hospice payment rates are the same as the Medicare hospice rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid participants. (7-1-06)T

c. Obligation of continuing care. After the participant's hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide that participant's care until the patient expires or until the participant revokes the election of hospice care. (7-1-06)T

457. HOSPICE - LIMITATION ON PAYMENTS FOR INPATIENT CARE.
Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve (12) month period beginning November 1st of each year and ending October 31st of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care) may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid participants

during the same period by the designated hospice or its contracted agent(s). (7-1-06)T

01. For Purposes of Computation. If it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows: (7-1-06)T

a. The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%). (7-1-06)T

b. If the total number of days of inpatient care to Medicaid hospice patients is less than or equal to the maximum number of inpatient days computed in Subsection 457.01 of these rules then no adjustment is made. (7-1-06)T

c. If the total number of days of inpatient care exceeds the maximum number of allowable inpatient days computed in Subsection 457.01 of these rules then the payment limitation will be determined by: (7-1-06)T

i. Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made. (7-1-06)T

ii. Multiplying excess inpatient care days by the routine home care rate. (7-1-06)T

iii. Adding the amounts calculated in Subsections 457.01.c.i. and 457.01.c.ii. of these rules. (7-1-06)T

iv. Comparing the amount in Subsection 457.01.c.iii. of these rules with interim payments made to the hospice for inpatient care during the "cap period". (7-1-06)T

02. The amount by which interim payments for inpatient care exceeds the amount calculated as in Subsection 456.01.c.iv. of these rules is due from the hospice. (7-1-06)T

458. HOSPICE - PAYMENT FOR PHYSICIAN SERVICES.
The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the participant's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. (7-1-06)T

01. Hospice Employed Physician Direct Patient Service. Reimbursement for a hospice employed physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for

physician services. These services will be billed by the hospice under the hospice provider number and, the related payments will be counted in determining whether the overall hospice cap amount per Section 459 of these rules has been exceeded. The only physician services to be billed by a hospice for such services are direct patient care services. Laboratory and X-ray services are included in the hospice daily rate. (7-1-06)T

02. Volunteer Physician Services. Volunteer physician services are excluded from Medicaid reimbursement with the following exceptions: (7-1-06)T

a. A hospice may be reimbursed on behalf of a volunteer physician for specific direct patient care services which are not rendered on a volunteer basis. The hospice must have a liability to reimburse the physician for those services rendered. In determining whether a service is provided on a volunteer basis, a physician must not distinguish which services are provided voluntarily on the basis of the patient's ability to pay. (7-1-06)T

b. Reimbursement for an independent physician's direct patient services which are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number and they will not be counted in determining whether the overall hospice cap amount per Section 459 of these rules has been exceeded. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or X-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice. (7-1-06)T

459. HOSPICE - CAP ON OVERALL REIMBURSEMENT.
Aggregate payments to each hospice will be limited during a hospice cap period per Subsection 451.05 of these rules. The total payments made for services furnished to Medicaid participants during this period will be compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. (7-1-06)T

01. Overall Cap. The overall cap will be compared to reimbursement after the inpatient limitation is computed and subtracted from total reimbursement due the hospice. (7-1-06)T

02. Total Payment for Services. Total payment made for services furnished to Medicaid participants during this period means all payments for services rendered during the cap year, regardless of when payment is actually made. (7-1-06)T

03. Calculation of Cap Amount. The "cap amount" is calculated by multiplying the number of participants electing certified hospice care during the period by six thousand five hundred dollars ($6,500). This amount will be adjusted for each subsequent cap year beginning November 1, 1983, to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers as published by the Bureau of Labor Statistics. It will also be adjusted as per Subsection 459.07 of these rules. (7-1-06)T

04. Computation and Application of Cap Amount. The computation and application of the "cap amount" is made by the Department after the end of the cap period.

(7-1-06)T

05. Report Number of Medicaid Participants. The hospice must report the number of Medicaid participants electing hospice care during the period to the Department. (7-1-06)T

a. This must be done within thirty (30) days after the end of the cap period: and (7-1-06)T

b. If the participant is transferred to a non-certified hospice no payment to the non-certified hospice will be made and the certified hospice may count a complete participant benefit period in their cap amount. (7-1-06)T

06. Certified in Mid-Month. If a hospice certifies in mid-month, a weighted average cap amount based on the number of days falling within each cap period would be used. (7-1-06)T

07. Adjustment of the Overall Cap. Cap amounts in each hospice's cap period will be adjusted to reflect changes in the cap periods and designated hospices during a participant's election period. The proportion of each hospice's days of service to the total number of hospice days rendered to the participant during their election period will be multiplied by the cap amount to determine each hospice's adjusted cap amount. (7-1-06)T

a. After each cap period has ended, the Department will calculate the overall cap within a reasonable time for each hospice participating in the Idaho Medicaid Program. (7-1-06)T

b. Each hospice's cap amount will be computed as follows: (7-1-06)T

i. The share of the "cap amount" that each hospice is allowed will be based on the proportion of total covered days provided by each hospice in the "cap period". (7-1-06)T

ii. The proportion determined in Subsection 456.05 of these rules for each certified hospice will be multiplied by the "cap amount" specified for the "cap period" in which the participant first elected hospice. (7-1-06)T

c. The participant must file an initial election during the period beginning September 28 of the previous year through September 27 of the current cap year in order to be counted as an electing Medicaid participant during the current cap year. (7-1-06)T

08. Additional Amount for Nursing Facility Residents. An additional per diem amount will be paid for "room and board" of hospice residents in a certified nursing facility receiving routine or continuous care services. In this context, the term "room and board" includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. The additional payments and the related days are not subject to the caps specified in Sections 457 and 459 of these rules. The room and board rate will be ninety-five percent (95%) of the per diem interim reimbursement rate assigned to the facility for those dates of service on which the participant was a resident of that facility. (7-1-06)T

460. HOSPICE - POST-ELIGIBILITY TREATMENT OF INCOME.
Where a participant is determined eligible for medical assistance participation in the cost of long term care, the Department must reduce its payments for all costs of the hospice benefit, including the supplementary amounts for room and board, by an amount determined according to Section 227 of these rules. (7-1-06)T

461. -- 499. (RESERVED).

SUB PART: ENHANCED DEVELOPMENTAL DISABILITY SERVICES
(Sections 500 Through 719)

500. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS.
Prior to receiving developmental disability services as provided in Sections 507 through 719 of these rules, the participant must be determined to have a developmental disability. (7-1-06)T

501. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS - ELIGIBILITY.
The definitions and standards in the table below must be used to determine whether a participant meets criteria as a person with a developmental disability under Section 66-402, Idaho Code.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
"Developmental Disability" means a chronic disability of a person which appears before the age of 22 years and:	Age of 22 means through the day before the individual's 22nd birthday. AND
(a) is attributable to an impairment, such as mental retardation,	"Is attributable to an impairment" means that there is a causal relationship between the presence of an impairing condition and the developmental disability. **Age 5 through Adult:** There is a presumption that mental retardation exists when a full scale IQ score up to 75 exists. (IQ of 70 with a standard error of measurement of 5 points.) **Birth to Age 5:** An IQ test score is not required below the age of 5. In these cases it may be necessary to rely on the results of a functional assessment. There is a presumption that mental retardation exists when there is a standard score of 75 or below or a delay of 30% overall.
cerebral palsy,	Medical Diagnosis which requires documentation.
epilepsy,	Medical Diagnosis which requires documentation. On medication controlled or uncontrolled. Does not include a person who is seizure-free and not on medication for 3 years.
autism,	Includes the diagnosis of pervasive developmental disorder.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services,	For related or similar conditions, documentation must be present to show the causal relationship between the impairing condition and the developmental disability. (Does not include mental illness) **Mental Retardation:** A full scale IQ score above 75 can in some circumstances be considered a related or similar condition to mental retardation when additional supporting documentation exists showing how the individual's functional limitations make their condition similar to mental retardation. **Cerebral Palsy:** Conditions related or similar to cerebral palsy include disorders which cause a similar disruption in motor function. **Epilepsy:** Conditions related or similar to epilepsy include disorders that interrupt consciousness.
or is attributable to dyslexia resulting from such impairments; and	AND
(b) results in substantial functional limitations in three (3) or more of the following major life activities;	"Results in" means that the substantial limitation must be because of the impairment. A "substantial" limitation is one in which the total effect of the limitation results in the need for a "combination and sequence of special interdisciplinary, or generic care, treatment or other services that need to be individually planned and coordinated." Listed below are standards for substantial functional limitations in each major life area. **Age 3 through Adult:** A score of 2 standard deviations below the mean creates a presumption of a functional limitation. **Birth to Age 3:** The following criteria must be utilized to determine a substantial functional limitations for children under 3: **a.** The child scores 30% below age norm; or **b.** The child exhibits a 6 month delay; or **c.** The child scores 2 standard deviations below the mean.
self care,	**Adult:** A substantial functional limitation is manifest when the person requires physical or non-physical assistance in performing eating, hygiene, grooming, or health care skills, or when the time required for a person to perform these skills him/her self is so substantial as to impair his ability to conduct other activities of daily living or retain employment. **Birth to Age 21:** A functional limitation is manifest when the child's skills are limited according to age-appropriate responses such that the parent, caregiver, or school personnel is required to provide care that is substantially beyond that typically required for a child of the same age (such as excessive time lifting, diapering, supervision).
receptive and expressive language,	**Age 3 through Adult:** A substantial functional limitation is manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). **Birth to Age 3:** A substantial functional limitation is manifest when they have been diagnosed by a qualified professional who determines that the child performs 30% below age norm (adjusted for prematurity up to 2 years) or demonstrates at least 2 standard deviations below the mean in either area or 1 1/2 below in both areas of language development.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
learning,	**Birth through Adult:** A substantial functional limitation is manifest when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that special (interventions that are beyond those that an individual normally needs to learn) intervention is required for the development of social, self care, language, academic, or vocational skills.
mobility,	**Adult:** A substantial functional limitation is manifest when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place. **Birth to Age 21:** A substantial limitation would be measured by an age appropriate instrument which compares the child's skills for postural control and movement and coordinated use of the small muscles with those skills expected of children of the same age.
self-direction,	**Adult:** A substantial functional limitation is manifest when a person requires assistance in managing his personal finances, protecting his self interest, or making decisions that may affect his well being. **Birth to Age 21:** A substantial limitation is manifest when the child is unable to help his self or cooperate with others age appropriate assistance to meet personal needs, learn new skills, follow rules, and adapt to environments.
capacity for independent living, or	**Adult:** A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. **Birth to Age 21:** A substantial limitation would be measured by an age-appropriate instrument which compares the child's personal independence and social responsibility expected of children of comparable age and cultural group.
economic self-sufficiency; and	**Adult:** A substantial functional limitation is manifest when a person is unable to perform the tasks necessary for regular employment or is limited in productive capacity to the extent that his earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. **Age 5 to Age 21:** Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. **Birth to Age 5:** A substantial limitation in this area is evidenced by the child's eligibility for SSI, early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA). AND

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
(c) reflects the needs 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 and coordinated.	**Age 5 through Adult:** Life-long or extended duration means the developmental disability is one which has the reasonable likelihood of continuing for a protracted period of time, including a reasonable likelihood that it will continue throughout life. **Birth to Age 5:** The expected duration may be frequently unclear. Therefore, determination of eligibility by a multi-disciplinary team for early intervention services through SSI, an IFSP, child study team or early childhood special education services through an IEP will be an indicator of this criteria.

(7-1-06)T

502. (RESERVED).

503. DEVELOPMENTAL DISABILITY DETERMINATION - TEST INSTRUMENTS. A variety of standardized test instruments are available. Tests used to determine a developmental disability must reflect the current functional status of the individual being evaluated. Tests over one (1) year old must be verified to reflect the current status of the individual by an appropriate professional. Instruments designed only for screening purposes must not be used to determine eligibility. (7-1-06)T

01. Test Instruments For Adults. Unless contra-indicated, the following test instruments or subsequent revisions must be used to determine eligibility: (7-1-06)T

a. Cognitive: Wechsler Adult Intelligence Scale-Third Edition (WAIS-III). (7-1-06)T

b. Functional: Scales of Independent Behavior-Revised (SIB-R). (7-1-06)T

02. Test Instruments For Children. The assessments utilized to determine eligibility must be based on age appropriate criteria. Evaluations must be performed by qualified personnel with experience and expertise with children; selected evaluation tools and practices should be age appropriate, based on consideration of the child's language and motor skills, be racially and culturally non-discriminatory, and be conducted in settings that are typically comfortable and familiar to the child. Unless contraindicated, test instruments such as the following must be used with children: (7-1-06)T

a. Cognitive: (7-1-06)T

i. Bayley Scales of Infant Development, Third Edition (BSID-III) for ages birth through forty-two (42) months; (7-1-06)T

ii. Stanford Binet Intelligence Scales, Fifth Edition (SB5) for ages two (2) years through adult; (7-1-06)T

iii. Wechsler Preschool and Primary Scale of Intelligence -Third Edition (WPPSI-III)

for ages two (2) years, six (6) months to seven (7) years, three (3) months; (7-1-06)T

iv. Wechsler Intelligence Scale for Children - Fourth Edition (WISC-IV) for ages six (6) through sixteen (16) years, eleven (11) months; or ~~(7-1-06)T~~(7-1-06)T

v. Wechsler Adult Intelligence Scale - Third Edition (WAIS-III) for ages sixteen (16) years to adult. (7-1-06)T

b. Functional: (7-1-06)T

i. American Association on Mental Retardation Adaptive Behavior Scale: School (ABS-S) for ages three (3) through twenty-one (21) years; (7-1-06)T

ii. Battelle Developmental Inventory, 2nd Edition (BDI-2) for ages birth to ninety-five (95) months; (7-1-06)T

iii. Developmental Profile II (DP-II) for ages birth through twelve (12) years; (7-1-06)T

iv. Scales of Independent Behavior (SIB-R) for ages birth through adult; (7-1-06)T

v. Vineland Adaptive Behavior Scales (VABS) for ages birth to eighteen (18) years, eleven (11) months; (7-1-06)T

vi. Mullen Scales of Early Learning (MSEL) for ages birth to three (3) years; (7-1-06)T

vii. Preschool Language Scale - 3 (PLS-3) for ages birth to three (3) years; (7-1-06)T

viii. Peabody Developmental Motor Scales for ages birth to three (3) years; or (7-1-06)T

ix. Receptive-Expressive Emergent Language Scale - Third Edition (REEL- 3) for ages birth to three (3) years. (7-1-06)T

504. -- 506. (RESERVED).

507. BEHAVIORAL HEALTH PRIOR AUTHORIZATION (PA).
The purpose of Behavioral Health Prior Authorization is to assure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of services, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service. (7-1-06)T

508. BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS - DEFINITIONS.

For the purposes of these rules the following terms are used as defined below. (7-1-06)T

01. **Adult**. A person who is eighteen (18) years of age or older or an ISSH Waiver participant. (7-1-06)T

02. **Assessment**. A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. (7-1-06)T

~~***03.*** ***Budget****. The level of financial support that corresponds to a participant's assessed needs, level of support determined by the SIB-R, and the past three (3) years' expenditures, when available. Using this information, the budget is negotiated with the plan developer, the participant, and the assessor.*~~ ~~*(7-1-06)T*~~

0~~*4*~~*3*. **Clinical Review**. A process of professional review that validates the need for continued services. (7-1-06)T

0~~*5*~~*4*. **Community Crisis Support**. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (7-1-06)T

0~~*6*~~*5*. **Concurrent Review**. A clinical review to determine the need for continued prior authorization of services. (7-1-06)T

~~***07.*** ***Customer****. Any stakeholder with the exception of the participant.*~~ ~~*(7-1-06)T*~~

0~~*8*~~*6*. **Exception Review**. A clinical review of a plan that falls outside the established standards. (7-1-06)T

0~~*9*~~*7*. **Interdisciplinary Team**. For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (7-1-06)T

~~*1*~~0~~*8*~~. **Level of Support**. An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (7-1-06)T

~~*11*~~*09*. **Person-Centered Planning Process**. A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (7-1-06)T

1~~*2*~~*0*. **Person-Centered Planning Team**. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (7-1-06)T

1~~*3*~~*1*. **Plan Developer**. A paid or non-paid person identified by the participant who is

responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (7-1-06)T

1~~4~~2. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. (7-1-06)T

1~~5~~3. Plan Monitor Summary. A summary that provides information to evaluate plans and initiate action to resolve any concerns. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status reviews referred to in Subsection 513.06 of these rules. The plan monitor will use the provider information to evaluate plans and initiate action to resolve any concerns. (7-1-06)T

1~~6~~4. Plan of Service. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (7-1-06)T

1~~7~~5. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (7-1-06)T

1~~8~~6. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (7-1-06)T

1~~9~~7. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (7-1-06)T

~~20~~18. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (7-1-06)T

~~21~~9. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (7-1-06)T

2~~2~~0. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (7-1-06)T

2~~3~~1. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (7-1-06)T

2~~4~~2. Service Coordinator. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Section*s* ~~*725*~~ *729 through 732* of these rules. ~~*(7-1-06)T*~~(7-1-06)T

2~~5~~3. Services. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (7-1-06)T

2~~6~~4. SIB-R. The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department to determine *developmental disability eligibility,* waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget. ~~*(7-1-06)T*~~(7-1-06)T

2~~7~~5. Supports. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (7-1-06)T

509. ~~*INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY*~~ BEHAVIORAL HEALTH PRIOR AUTHORIZATION - ELIGIBILITY DETERMINATION.
The Department will make the final determination of an individual's eligibility, based upon the assessments and evaluations administered by the Department. Initial and annual assessments must be performed by the Department. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules and for ICF/MR level of care for waiver services in accordance with Section ~~*583*~~ *584* of these rules. ~~*(7-1-06)T*~~(7-1-06)T

01. Initial Assessment. For new applicants, an assessment must be completed within thirty (30) days from the date a completed application is submitted. (7-1-06)T

02. Annual Assessments. Assessments must also be completed for current participants at the time of their annual eligibility redetermination. The assessor must evaluate whether assessments are current and accurately describe the status of the participant. At least sixty (60) days before the expiration of the current plan of service: (7-1-06)T

a. The assessment process must be completed; and (7-1-06)T

b. The assessor must provide the results of the assessment to the participant. (7-1-06)T

03. Determination of Developmental Disability Eligibility. The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services must include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on mental retardation and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than mental retardation. A SIB-R will be administered by the Department for use in this determination. (7-1-06)T

04. ICF/MR Level of Care Determination for Waiver Services. The assessor will determine ICF/MR level of care for adults in accordance with Section ~~*583*~~ *584* of these rules. ~~*(7-1-06)T*~~(7-1-06)T

510. (RESERVED).

511. INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY - COVERAGE AND LIMITATIONS.
The scope of these rules defines prior authorization for the following Medicaid behavioral health services for adults: (7-1-06)T

01. DD/ISSH Waiver Services. DD/ISSH Waiver services as described in Sections 700 through 719 of these rules; and (7-1-06)T

02. Developmental Disability Agency Services. Developmental Disability Agency services as described in Sections 650 through 660 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies"; and (7-1-06)T

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (7-1-06)T

512. BEHAVIOR HEALTH PRIOR AUTHORIZATION - PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (7-1-06)T

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD and ISSH waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (7-1-06)T

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (7-1-06)T

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (7-1-06)T

03. Medical, Social, and Developmental History. (7-1-06)T

04. SIB-R. The results of the SIB-R are used to determine the level of support for the participant. A current SIB-R assessment must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. (7-1-06)T

05. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (7-1-06)T

06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require

special consideration. (7-1-06)t

513. BEHAVIOR HEALTH PRIOR AUTHORIZATION - PLAN OF SERVICE.
In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (7-1-06)T

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Section*s* 729 *through 732* of these rules. ~~*(7-1-06)T*~~(7-1-06)T

02. Plan Development. The plan must be developed with the participant. With the participant's consent, the person-centered planning team may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The plan of service must be submitted within ~~*thirty*~~ *forty-five* (~~*30*~~*45*) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. ~~*(7-1-06)T*~~(7-1-06)T

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (7-1-06)T

a. Durable Medical Equipment (DME); (7-1-06)T

b. Transportation; and (7-1-06)T

c. Physical, speech and occupational therapy provided outside of a Development Disabilities Agency (DDA). (7-1-06)T

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services if there are multiple plans of service. Duplicate services will not be authorized. (7-1-06)T

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (7-1-06)T

a. Review of the plan of service in a face-to-face contact with the participant to

identify the current status of programs and changes if needed; (7-1-06)T

b. Contact with service providers to identify barriers to service provision; (7-1-06)T

c. Discuss with participant satisfaction regarding quality and quantity of services; and (7-1-06)T

d. Review of provider status reviews and complete a plan monitor summary after the six (6) month review and for annual plan development. (7-1-06)T

e. Immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Regional Medicaid Services (RMS), the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (7-1-06)T

06. Provider Status Reviews. Service providers, with exceptions identified in S*ubs*ection ~~*341*~~ *513.11* of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: ~~*(7-1-06)T*~~(7-1-06)T

a. The status of supports and services to identify progress; (7-1-06)T

b. Maintenance; or (7-1-06)T

c. Delay or prevention of regression. (7-1-06)T

07. Plan Monitor Summary. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status review. (7-1-06)T

08. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (7-1-06)T

09. Negotiation for the Plan of Service. The plan of service must be individualized with the participant if the requested services fall outside the ~~*negotiated*~~ *individualized* budget or do not reflect the assessed needs. When the plan of service cannot be negotiated by the assessor, the plan developer, and the participant, it will be referred by the assessor to the Department's care manager for additional evaluation. Services will not be paid for unless they are authorized on the plan of service. ~~*(7-1-06)T*~~(7-1-06)T

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

Consumer Relations Specialist to negotiate a resolution with members of the planning team. (7-1-06)T

11. Provider Implementation Plan. Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (7-1-06)T

a. Exceptions. An implementation plan is not required for waiver providers of: (7-1-06)T

i. Specialized medical equipment; (7-1-06)T

ii. Home delivered meals; (7-1-06)T

iii. Environmental modifications; (7-1-06)T

iv. Non-medical transportation; (7-1-06)T

v. Personal emergency response systems (PERS); (7-1-06)T

vi. Respite care; and (7-1-06)T

vii. Chore services. (7-1-06)T

b. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. (7-1-06)T

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (7-1-06)T

12. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. (7-1-06)T

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

consecutive five (5) day period. (7-1-06)T

a. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (7-1-06)T

b. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (7-1-06)T

c. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. (7-1-06)T

14. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (7-1-06)T

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least ~~*thirty*~~ *forty-five* (~~*30*~~*45*) days prior to the expiration date of the current plan. Prior to this, the plan developer must: ~~*(7-1-06)T*~~(7-1-06)T

i. Notify the providers who appear on the plan of service of the annual review date. (7-1-06)T

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.14.d of these rules. (7-1-06)T

iii. Convene the person-centered planning team to develop a new plan of service. (7-1-06)T

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (7-1-06)T

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (7-1-06)T

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.12 of these rules. (7-1-06)T

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (7-1-06)T

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (7-1-06)T

15. Reconsiderations, Complaints, And Administrative Appeals

a. Reconsideration. Participants with developmental disabilities who are adversely affected by a Department decision regarding program eligibility and authorization of services under these rules may request a reconsideration within twenty-eight (28) days from the date the decision was mailed. The reconsideration must be performed by an interdisciplinary team as determined by the Department with at least one (1) individual who was not involved in the original decision. The reviewers must consider all information and must issue a written decision within fifteen (15) days of receipt of the request. (7-1-06)T

b. Complaints. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid, Bureau of Care Management. (7-1-06)T

c. Administrative Appeals. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-06)T

514. BEHAVIORAL HEALTH PRIOR AUTHORIZATION - ~~*PAYMENT METHODOLOGY*~~ *PROVIDER REIMBURSEMENT*.
Providers are reimbursed on a fee for service basis based on a participant budget. (7-1-06)T

01. Methodology for Developing Participant Budget Prior to October 1, 2006. The participant budget is developed using the following methodology: (7-1-06)T

a. Evaluate the past three (3) years of Medicaid expenditures from the participant's profile, excluding physician, pharmacy, and institutional services; (7-1-06)T

b. Review all assessment information identified in Section 512 of these rules; (7-1-06)T

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

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

(7-1-06)T

d. Correlate the level of support identified by the SIB-R to a budget range derived from the expenditures of individuals at the same level of support across the adult DD population. This correlation will occur annually prior to the development to the plan of service; (7-1-06)T

02. Negotiating an Appropriate Participant Budget Prior to October 1, 2006. The assessor, the participant, and the plan developer must use all the information from Subsections 514.01.a. through 514.01.d. of these rules to negotiate an appropriate budget that will support the participant's identified needs. (7-1-06)T

03. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD and ISSH waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (10-1-06)T

a. During the implementation phase of using the new individualized budget-setting methodology, the budget calculation will include reviewing the participant's previous year's budget. When the calculated budget is less than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the calculated budget amount. When the calculated budget is greater than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the previous year's budget amount. The Department will collect information on discrepancies between the calculated budget and the previous year's budget as part of the ongoing assessment and improvement process of the budget-setting methodology. (10-1-06)T

b. The Department notifies each participant of his set budget amount. The notification will include how the participant may request reconsideration of the set budget amount (10-1-06)T

c. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget. (10-1-06)T

04. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. ~~*As these outcomes are met, participants must transition to less intense supports. Residential habilitation - supported living is available at the following levels:*~~ *As a participant's independence increases and he is less dependent on supports, he must transition to less intense supports.* ~~*(7-1-06)T*~~(7-1-06)T

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision and have an SIB-R Support Level of Pervasive, Extensive, or Frequent. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. (7-1-06)T

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (7-1-06)T

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (7-1-06)T

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (7-1-06)T

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (7-1-06)T

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

condition and the need for this level of service requires medical documentation. (7-1-06)T

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed ~~more than one hundred and ninety dollars ($190) per day~~ the maximum set daily amount established by the Department except when all of the following conditions are met: ~~(7-1-06)T~~(7-1-06)T

i. The participant is eligible to receive the high support daily rate; (7-1-06)T

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (7-1-06)T

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (7-1-06)T

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (7-1-06)T

515. BEHAVIORAL HEALTH - QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may terminate authorization of service for providers who do not comply with the corrective action plan. (7-1-06)T

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (7-1-06)T

03. Exception Review. The Department will complete a clinical review of plans of service that exceed the budget authorized by the assessor or are inconsistent with the participant's assessed needs. The supporting documentation must demonstrate the medical necessity of services in the plan of service. (7-1-06)T

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. (7-1-06)T

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (7-1-06)T

516. -- 579. (RESERVED).

580. INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR).
The Department will pay for services in an ICF/MR. ICFs/MR are intermediate care facilities whose primary purpose is to provide habilitative services and maintain optimal health status for individuals with mental retardation or persons with related conditions. (7-1-06)T

581. ~~(RESERVED)~~ *ICF/MR - ELIGIBILITY*.
Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Regional Nurse Reviewer (RNR) has determined that the individual meets the criteria for ICF/MR services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. *(7-1-06)T*

582. ICF/MR - DETERMINATION OF ENTITLEMENT FOR MEDICAID PAYMENT.
Applications for Medicaid payment of an individual with mental retardation, or related condition, in an ICF/MR will be through the Department's RMS staff. All required information necessary for a medical entitlement determination~~, including DDC's recommendation for placement and services,~~ must be submitted to the Regional Medicaid Services before a determination and approval for payment is made. The effective date of Medicaid payment will be no earlier than the physician's signed and dated certification for ICF/MR level of care. ~~(7-1-06)T~~(7-1-06)T

583. ICF/MR - INFORMATION REQUIRED FOR DETERMINATION.
Required information includes a medical evaluation, an initial plan of care, social evaluation, psychological evaluation, and initial plan of care by ICF/MR. (7-1-06)T

01. Medical Evaluation. A complete medical evaluation, current within ninety (90) days of admission, signed and dated by the physician, an electronic physician's signature is permissible, which includes: (7-1-06)T

a. Diagnosis (primary and secondary); (7-1-06)T

b. Medical findings and history; (7-1-06)T

c. Mental and physical functional capacity; (7-1-06)T

d. Prognosis; mobility status; and (7-1-06)T

e. A statement by the physician certifying the level of care needed as ICF/MR for a specific participant. (7-1-06)T

02. Initial Plan of Care by Physicians. An initial plan of care, current within ninety (90) days of admission and signed and dated by the physician which includes: (7-1-06)T

a. Orders for medications and treatments; (7-1-06)T

b. Diet; and (7-1-06)T

c. Professional rehabilitative and restorative services and special procedures, where appropriate. (7-1-06)T

03. Social Evaluation. A social evaluation, current within ninety (90) days of admission, which includes: (7-1-06)T

a. Condition at birth; (7-1-06)T

b. Age at onset of condition; (7-1-06)T

c. Summary of functional status, such as skills level, activities of daily living; and (7-1-06)T

d. Family social information. (7-1-06)T

04. Psychological Evaluation. A psychological evaluation conducted by a psychologist current within ninety (90) days of admission, which includes: (7-1-06)T

a. Diagnosis; (7-1-06)T

b. Summary of developmental findings. Instead of a psychological, infants under three (3) years of age may be evaluated by a developmental disability specialist utilizing the developmental milestones congruent with the age of the infant; (7-1-06)T

c. Mental and physical functioning capacity; and (7-1-06)T

d. Recommendation concerning placement and primary need for active treatment. (7-1-06)T

05. Initial Plan of Care by ICF/MR. An initial plan of care developed by the admitting ICF/MR. (7-1-06)T

584. ICF/MR - CRITERIA FOR DETERMINING ELIGIBILITY.
Individuals who have mental retardation or a related condition as defined in Section 66-402, Idaho Code and Sections 500 through 503 of these rules, must be determined by an interdisciplinary team to need the consistent, intense, frequent services including active treatment provided in an ICF/MR *or receive services under one of Idaho's programs to assist individuals with mental retardation or a related condition to avoid institutionalization in an ICF/MR*, as indicated in Section 584.02 of these rules. To meet Title XIX and Title XXI entitlement for ICF/MR level of care and be eligible for services provided in an ICF/MR. The following must be met in Subsections 584.01 though 584.08 of these rules. ~~*(7-1-06)T*~~(7-1-06)T

01. Diagnosis. Persons must be financially eligible for Medicaid; must have a primary diagnosis of mental retardation or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. (7-1-06)T

02. Active Treatment. Persons living in an ICF/MR, must require and receive intensive inpatient active treatment as defined in Section 010 of these rules, to advance or maintain his functional level. (7-1-06)T

a. Active treatment does not include: parenting activities directed toward the acquisition of age-appropriate developmental milestones; services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program or services; interventions that address age-appropriate limitations; or general supervision of children who's age is such that such supervision is required by all children of the same age. (7-1-06)T

b. The following criteria/components will be utilized when evaluating the need for active treatment: (7-1-06)T

i. Evaluation. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the participant and the interventions needed; and (7-1-06)T

ii. Plan of Care. A written plan of care which sets forth initial goals and objectives, specifies further evaluations to be done, and training programs to be developed. (7-1-06)T

03. Must Require Certain Level of Care. Persons living in the community must require the level of care provided in an ICF/MR, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization*, other than services in an institution for mental disease,* in the near future. ~~*(7-1-06)T*~~(7-1-06)T

04. Care for a Child. The department may provide Medicaid to a child eighteen (18) years of age or younger, who would be eligible for Medicaid if they were in a medical institution and who are receiving, while living at home, medical care that would be provided in a medical institution, if the Department determines that the child requires the level of care provided in an ICF/MR. (7-1-06)T

05. Functional Limitations. (7-1-06)T

a. Persons Sixteen Years of Age or Older. Persons (sixteen (16) years of age or older) may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment (Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions) would qualify; or (7-1-06)T

b. Persons Under Sixteen Years of Age. Persons (under sixteen (16) years of age) qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or (7-1-06)T

06. Maladaptive Behavior. (7-1-06)T

a. A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/MR

level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revision is minus twenty-two (-22) or less; or (7-1-06)T

b. Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/MR level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or (7-1-06)T

07. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/MR level of care if they display a combination of ~~*Criterion 1 and 2*~~ *criteria as described in Subsections 585.05 and 585.06 of these rules* at a level that is significant and it can been determined they are in need of the level of services provided in an ICF/MR, including active treatment services. Significance would be defined as: ~~*(7-1-06)T*~~(7-1-06)T

a. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R up to minus seventeen (-17), minus twenty-two (-22) inclusive; or (7-1-06)T

b. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R between minus seventeen (-17), and minus twenty-one (-21) inclusive; or (7-1-06)T

08. Medical Condition. Individuals may meet ICF/MR level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/MR, including active treatment services. (7-1-06)T

09. Annual Redetermination for ICF/MR Level of Care for Community Services. *The RMS staff must redetermine the participant's continuing need for ICF/MR level of care for community services. Documentation will consist of the completion of a redetermination statement on the "Level of Care" form HW0083. Such documentation will be accomplished no later than every three hundred sixty-five (365) days from the most recent determination.* *(7-1-06)T*

a. *Home Care for Certain Disabled Children (HCDC). Persons receiving HCDC Medicaid services through ICF/MR eligibility, will receive services until the end of the month in which the redetermination was made. These individuals must receive ten (10) days notification of termination of services. If the redetermination is made less than ten (10) days from the end of the month, payment continues until the end of the following month.* *(7-1-06)T*

b. *Developmentally Disabled Waiver. Individuals receiving developmentally disabled waiver services will have thirty (30) days from the time of the determination to transition to other community supports.* *(7-1-06)T*

585. ICF/MR - COVERAGE REQUIREMENTS AND LIMITATIONS.

The minimum content of care and services for ICF/MR must include the services listed below and social and recreational activities. (7-1-06)T

01. Care and Services Provided. (7-1-06)T

a. The minimum content of care and services for ICF/MR participants must include the following: (7-1-06)T

i. Room and board; and (7-1-06)T

ii. Bed and bathroom linens; and (7-1-06)T

iii. Nursing care, including special feeding if needed; and (7-1-06)T

iv. Personal services; and (7-1-06)T

v. Supervision as required by the nature of the participant's illness; and (7-1-06)T

vi. Special diets as prescribed by a participant's physician; and (7-1-06)T

vii. All common medicine chest supplies which do not require a physician's prescription including but not limited to mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; and (7-1-06)T

viii. Dressings; and (7-1-06)T

ix. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; and (7-1-06)T

x. Application or administration of all drugs; and (7-1-06)T

xi. All medical supplies including but not limited to gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton or any other type of pads used to save labor or linen, and disposable gloves; and (7-1-06)T

xii. Social and recreational activities; and (7-1-06)T

xiii. Items which are utilized by individual participants but which are reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. (7-1-06)T

02. Wheelchairs. DHW authorized purchases of specialized wheelchair and seating systems, and any authorized repairs related to the seating system, which are paid to a medical vendor directly by DHW will not be included in the content of care of ICFs/MR. The specialized wheelchairs and seating systems must be designed to fit the needs of a specific ICF/MR resident and cannot be altered to fit another participant cost effectively. (7-1-06)T

586. ICF/MR - PROCEDURAL RESPONSIBILITIES.
Each long term care facility administrator, or his authorized representative, must report to the appropriate Field Office within three (3) working days of the date the facility has knowledge of the following. (7-1-06)T

01. Readmissions or Discharges. Any readmission or discharge of a participant, and any temporary absence of a participant due to hospitalization or therapeutic home visit. (7-1-06)T

02. Changes to Participant's Income. Any changes in the amount of a participant's income. (7-1-06)T

03. Participant's Account Exceeds Limitations. When a participant's account has exceed the following amount; (7-1-06)T

a. For a single individual, one thousand eight hundred dollars ($1,800);or 7-1-06)T

b. For a married couple, two thousand eight hundred dollars ($2,800). (7-1-06)T

04. Other Financial Information for Participant. Other information about a participant's finances which may potentially affect eligibility for medical assistance. (7-1-06)T

~~***05. Annual Redetermination for ICF/MR Level of Care**. The RMS staff must redetermine the participant's continuing need for ICF/MR level of care for community services. Documentation will consist of the completion of a redetermination statement on the "Level of Care" form HW0083. Such documentation will be accomplished no later than every three hundred sixty-five (365) days from the most recent determination. (7-1-06)T~~

~~***a.** Transitioning to a Less Restrictive Environment. Persons living in an ICF/MR will be transitioned to a less restrictive environment within thirty (30) days of the determination that the participant does not meet ICF/MR level of care. (7-1-06)T~~

~~***b.** Home Care for Certain Disabled Children (HCDC). Persons receiving HCDC Medicaid services through ICF/MR eligibility, will receive services until the end of the month in which the redetermination was made. These individuals must receive ten (10) days notification of termination of services. If the redetermination is made less than ten (10) days from the end of the month, payment continues until the end of the following month. (7-1-06)T~~

~~***c.** Developmentally Disabled Waiver. Individuals receiving Developmentally Disabled waiver services will have thirty (30) days from the time of the determination to transition to other community supports. (7-1-06)T~~

0~~6~~5. Annual Recertification Requirement. It is the responsibility of the ICF/MR to assure that the recertification is accomplished by the physician, physician's assistant or nurse practitioner no later than every three hundred sixty-five (365) days. (7-1-06)T

a. Should the Medicaid Program receive a financial penalty from the Department of Health and Human Services due to the lack of appropriate recertification on the part of an ICF/

MR, then such amount of money will be withheld from facility payments for services provided to Medicaid participants. For audit purposes, such financial losses are not reimbursable as a reasonable cost of participant care. Such losses cannot be made the financial responsibility of the Department's participant. ~~(7-1-06)T~~(7-1-06)T

b. *Persons living in an ICF/MR will be transitioned to a less restrictive environment within thirty (30) days of the determination that the participant does not meet ICF/MR level of care.* *(7-1-06)T*

0~~7~~6. Level of Care Change. If during an on-site review of a resident's medical record and an interview with or observation of the resident an IOC/UC reviewer determines there is a change in the resident's status and the resident no longer meets criteria for ICF/MR care, the tentative decision is: (7-1-06)T

a. Discussed with the facility administrator or the director of nursing services; (7-1-06)T

b. The resident's physician is notified of the tentative decision; (7-1-06)T

c. The case is submitted to the Regional Review Committee for a final decision; and (7-1-06)T

d. The effective date of loss of payment will be no earlier than ten (10) days following the date of mailing of notice to the participant by the Eligibility Examiner. (7-1-06)T

0~~8~~7. Appeal of Determinations. The resident or his representative may appeal the decisions under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-06)T

0~~9~~8. Supplemental On-Site Visit. The Regional Nurse Reviewer may conduct utilization control supplemental on-site visits in an ICF/MR when indicated. Some indications may be: (7-1-06)T

a. Follow-up activities; (7-1-06)T

b. A verification of a participant's appropriateness of placement or services; and (7-1-06)T

c. Conduct complaint investigations at the Department's request. (7-1-06)T

~~1~~09. Determination of Entitlement to Long-Term Care. Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Regional Nurse Reviewer has determined that the individual meets the criteria for ICF/MR care and services. Entitlement must be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. (7-1-06)T

a. The criteria for determining a Participant's need for intermediate care for the

mentally retarded is described in Sections 583 and 584 of these rules. In addition, the IOC/UC nurse must determine whether a Participant's needs could be met by non-participant inpatient alternatives including, but not limited to, remaining in an independent living arrangement or residing in a room and board situation. (7-1-06)T

b. The participant can select any certified facility to provide the care required. (7-1-06)T

c. The final decision as to the level of care required by a Participant must be made by the IOC/UC Nurse. (7-1-06)T

d. The final decision as to the need for DD or MI active treatment must be made by the appropriate Department staff as a result of the Level II screening process. (7-1-06)T

e. No payment must be made by the Department on behalf of any eligible Participant to any long-term care facility which, in the judgment of the Inspection Of Care/Utilization Control Team is admitting individuals for care or services which are beyond the facility's licensed level of care or capability. (7-1-06)T

1~~1~~*0*. **Authorization of Long-Term Care Payment**. If it has been determined that a person eligible for medical assistance is entitled to medical assistance participation in the cost of long-term care, and that the facility selected by the participant is licensed and certified to provide the level of care the participant requires, the Field Office will forward to such facility an "Authorization for Long-Term Care Payment" form HW 0459. (7-1-06)T

587. ICF/MR - PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Application and Certification. A facility must apply to participate as an ICF/MR facility. (7-1-06)T

02. Licensure and Certification. (7-1-06)T

a. Upon receipt of an application from a facility, the Licensing and Certification Agency *must conduct a survey to* determine~~s~~ the facility's compliance with certification standards for the type of care the facility proposes to provide to participants. ~~*(7-1-06)T*~~(7-1-06)T

b. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for ICF/MR, the Department must certify to the appropriate branch of government that the facility meets the standards for ICF/MR types of care. (7-1-06)T

c. Upon receipt of the certification from the Licensing and Certification Agency, the Bureau may enter into a provider agreement with the long-term care facility. (7-1-06)T

d. After the provider agreement has been executed by the Facility Administrator and by the Chief of the Bureau, one (1) copy must be sent by certified mail to the facility and the original is to be retained by the Bureau. (7-1-06)T

03. Direct Care Staff. Direct Care staff in an ICF/MR are defined as the present on-

duty staff calculated over all shifts in a twenty-four (24) hour period for each defined residential living unit. Direct care staff in an ICF/MR include those employees whose primary duties include the provision of hands-on, face-to-face contact with the participants of the facility. This includes both regular and live-in/sleep-over staff. It excludes professionals such as psychologists, nurses, and others whose primary job duties are not the provision of direct care, as well as managers/ supervisors who are responsible for the supervision of staff. (7-1-06)T

04. Direct Care Staffing Levels. The reasonable level of direct care staffing provided to a participant in an ICF/MR setting will be dependent upon the level of involvement and the need for services and supports of the participant as determined by the Department. Level of involvement relates to the severity of a participant's mental retardation. Those levels, in decreasing level of severity, are: profound, severe, moderate, and mild. Staffing levels will be subject to the following constraints: (7-1-06)T

a. Direct care staffing for a severely and profoundly retarded participant residing in an ICF/MR must be a maximum of sixty-eight point twenty five (68.25) hours per week. (7-1-06)T

b. Direct care staffing for a moderately retarded participant residing in an ICF/MR must be limited to a maximum of fifty-four point six (54.6) hours per week. (7-1-06)T

c. Direct care staffing for a mildly retarded participant residing in an ICF/MR must be limited to a maximum of thirty four point one two five (34.125) hours per week. (7-1-06)T

05. Direct Care Staff Hours. The annual sum total level of allowable direct care staff hours for each residential living unit will be determined in the aggregate as the sum total of the level of staffing allowable for each resident residing in that residential living unit as determined in Subsection 587.04 of these rules. (7-1-06)T

06. Phase-in Period. If enactment of Subsection 587.04 of these rules requires a facility to reduce its level of direct care staffing, a six (6) month phase-in period will be allowed from the date of the enactment of this section, without any resulting disallowances. Should disallowances result, the hourly rate of direct care staff used in determining disallowances will be the weighted average of the hourly rates paid to a facility's direct care staff, plus the associated benefits, at the end of the phase-in period. (7-1-06)T

07. Exceptions. Should a provider be able to show convincing evidence documenting that the annual aggregate direct care hours as allowed under this section will compromise their ability to supply adequate care to the participants, as required by federal regulations and state rules, within an ICF/MR residential living unit and that other less costly options would not alleviate the situation, the Department will approve an additional amount of direct care hours sufficient to meet the extraordinary needs. This adjustment will only be available up through September 30, 1996. (7-1-06)T

588. ICF/MR - ~~*PAYMENT METHODOLOGY*~~ *PROVIDER REIMBURSEMENT*.

01. Payment Methodology. ICF/MR facilities will be reimbursed in accordance with the methodology listed in Sections 588 through 633 of these rules. (7-1-06)T

02. ~~***Nonlegend Drugs Reimbursement***~~. ***Date of Discharge***. *Payment by the Department for the cost of ICF/MR care is to include the date of the participant's discharge only if the discharge occurred after 3 p.m. and is not discharged to a related provider. If a Medicaid patient dies in an ICF/MR, his date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care will be deemed to exist*. ~~*(7-1-06)T*~~(7-1-06)T

~~***a.*** *For providers which have no pharmacy on the premises, reimbursement will be available for nonlegend drugs subject to a test of reasonableness related to the market place and must not exceed the pharmacist's charges to private pay patients. This means that charges to the patient may not exceed the billing to the provider including, adjustments by discounts or terms.* *(7-1-06)T*~~

~~***b.*** *For providers who have a pharmacy on the premises, reimbursement will be available for nonlegend drugs at cost plus a dispensing fee established by the Division of Medicaid.* *(7-1-06)T*~~

~~***03.*** ***Record-Keeping Requirements for Drug Purchases***. *According to the requirements in the Provider Reimbursement Manual (PRM), Section 2104, the provider, as part of its financial record-keeping responsibility under the Medicaid Assistance Program must have on supplier invoices all needed cost verification information including name brand, quantity, form, and strength of the drugs supplied and the provider's actual cost. In the absence of such information and in accordance with Title XVIII of the Social Security Act, Section 1815 and 42 CFR 405.453, the Department must deny charges for unlabeled drugs because of inadequate records. Any cost reductions received on drug purchases including discounts, cash, trade, purchase, and quantity, or rebates, must also be clearly reflected on the individual invoices or related documentation.* *(7-1-06)T*~~

589. ICF/MR - REASONABLE COST PRINCIPLES.
To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to beneficiaries will result. (7-1-06)T

01. Application of Reasonable Cost Principles. (7-1-06)T

a. Reasonable costs of any services are determined in accordance with rules found in the Provider Reimbursement Manual (PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. (7-1-06)T

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. (7-1-06)T

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. (7-1-06)T

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Chapter 1, Idaho Code, or are unallowable by application of promulgated regulation. (7-1-06)T

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (7-1-06)T

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. (7-1-06)T

02. Costs Related to Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Example: Depreciation is a method of systematically recognizing the declining utility value of an asset. To the extent that the asset is related to patient care, reasonable, ordinary, and necessary, the related expense is allowable when reimbursed based on property costs according to other provisions of this chapter. Property related expenses are likewise allowable. (7-1-06)T

03. Costs Not Related to Patient Care. Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. Example: Fines are imposed for late remittance of federal withholding taxes. Such fines are not related to patient care, are not necessary, and are not reflective of prudent cost conscious management. Therefore, such fines and penalties are not allowable. (7-1-06)T

04. Form and Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. Example: Lease-Purchase agreements are contracts which are executed in the form of a lease. The wording of the contract is couched in such a manner as to give the reader the impression of a true rental-type lease. However, the substance of this contract is a purchase of the property. If a lease contract is found to be in substance a purchase, the related payments are not allowable as lease or rental expense. (7-1-06)T

590. ICF/MR - ALLOWABLE COSTS.
The following definitions and explanations apply to allowable costs: (7-1-06)T

01. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable. (7-1-06)T

02. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for

patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement can not exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee. (7-1-06)T

03. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable as provided in PRM, Section 300. (7-1-06)T

04. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (7-1-06)T

05. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Section 597 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: (7-1-06)T

a. Salaries wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (7-1-06)T

b. Supplies and services provided for the owner's personal use. (7-1-06)T

c. Compensation paid by the facility to employees for the sole benefit of the owner. (7-1-06)T

d. Fees for consultants, directors, or any other fees paid regardless of the label. (7-1-06)T

e. Keyman life insurance. (7-1-06)T

f. Living expenses, including those paid for related persons. (7-1-06)T

06. Contracted Service. All services which are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (7-1-06)T

07. Depreciation. Depreciation on buildings and equipment is an allowable property

expense subject to Section 630 of these rules. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. (7-1-06)T

08. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met. (7-1-06)T

09. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. (7-1-06)T

10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable. (7-1-06)T

11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment. (7-1-06)T

12. Food. Costs of raw food, not including vending machine items, are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food. (7-1-06)T

13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers. (7-1-06)T

14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. (7-1-06)T

15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (7-1-06)T

16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices and ICF/MR day treatment services will not be reported as property costs and will be allowable based on reasonable cost principles subject to other limitations contained herein. (7-1-06)T

17. Malpractice or Public Liability Insurance. Premiums for malpractice and public liability insurance must be reported as administrative costs. (7-1-06)T

18. **Payroll Taxes**. The employer's portion of payroll taxes is reimbursable. (7-1-06)T

19. **Property Costs**. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. For ~~*free-standing nursing facilities and*~~ ICFs/MR, the property rental rate is paid as described in Section 630 of these rules. ~~*Hospital- based nursing facilities are paid based on property costs.* *(7-1-06)T*~~(7-1-06)T

a. Amortization of leasehold improvements will be included in property costs. (7-1-06)T

i Straight line depreciation on fixed assets is included in property costs. (7-1-06)T

ii. Depreciation of moveable equipment is an allowable property cost. (7-1-06)T

b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities. (7-1-06)T

20. **Property Insurance**. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (7-1-06)T

21. **Repairs and Maintenance**. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (7-1-06)T

22. **Salaries**. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost. (7-1-06)T

23. **Supplies**. Cost of supplies used in patient care or providing services related to patient care is allowable. (7-1-06)T

24. **Taxes**. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs. (7-1-06)T

591. ICF/MR - NONALLOWABLE COSTS.
The following definitions and explanations apply to nonallowable costs: (7-1-06)T

01. **Accelerated Depreciation**. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable. (7-1-06)T

02. **Acquisitions**. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable. (7-1-06)T

03. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable. (7-1-06)T

04. Charity Allowances. Cost of free care or discounted services are nonallowable. (7-1-06)T

05. Consultant Fees. Costs related to the payment of consultant fees in excess of the lowest rate available to a facility are nonallowable. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified, unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This subsection in no way limits the Department's ability to disallow excessive consultant costs under other sections of this chapter, such as Section 589 or 595 of these rules, when applicable. (7-1-06)T

06. Fees. Franchise fees are nonallowable, see PRM, Section 2133.1. (7-1-06)T

07. Fund Raising. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2. (7-1-06)T

08. Goodwill. Costs associated with goodwill as defined in Section 011 of these rules are nonallowable. (7-1-06)T

09. Holding Companies. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A. (7-1-06)T

10. Interest. Interest to finance nonallowable costs are nonallowable. (7-1-06)T

11. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable. (7-1-06)T

12. Nonpatient Care Related Activities. All activities not related to patient care are nonallowable. (7-1-06)T

13. Organization. Organization costs are nonallowable, see PRM, Section 2134. (7-1-06)T

14. Pharmacist Salaries. Salaries and wages of pharmacists are nonallowable. (7-1-06)T

15. Prescription Drugs. Prescription drug costs are nonallowable. (7-1-06)T

16. Related Party Interest. Interest on related party loans are nonallowable, see

PRM, Sections 218.1 and 218.2. (7-1-06)T

17. Related Party Nonallowable Costs. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated. (7-1-06)T

18. Related Party Refunds. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. (7-1-06)T

19. Self-Employment Taxes. Self-employment taxes, as defined by the Internal Revenue Service, which apply to facility owners are nonallowable. (7-1-06)T

20. Telephone Book Advertising. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable. (7-1-06)T

21. Vending Machines. Costs of vending machines and cost of the product to stock the machine are nonallowable costs. (7-1-06)T

592. ICF/MR - HOME OFFICE COST PRINCIPLES.
The reasonable cost principles will extend to the home office costs allocated to individual providers. In addition, the home office, through the provider, will provide documentation as to the basis used to allocate its costs among the various entities it administers or otherwise directs. (7-1-06)T

~~***593. -- 594. (RESERVED).***~~

593. ICF/MR - RELATED PARTY TRANSACTIONS.

***01. Principle**. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (7-1-06)T*

***02. Cost Allowability - Regulation**. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. (7-1-06)T*

594. ICF/MR - APPLICATION OF RELATED PARTY TRANSACTIONS.

***01. Determination of Common Ownership or Control in the Provider Organization and Supply Organization**. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (7-1-06)T*

***a.** A determination as to whether an individual(s) possesses ownership or equity in*

the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. *(7-1-06)T*

b. *The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise.* *(7-1-06)T*

02. ***Cost to Related Organizations****. The charges to the provider from related organizations may not exceed the billing to the related organization for these services.* *(7-1-06)T*

03. ***Costs Not Related to Patient Care****. All home office costs not related to patient care are not allowable under the program.* *(7-1-06)T*

04. ***Interest Expense****. Generally, interest expense on loans between related entities will not be reimbursable. See the PRM, Chapters 2, 10, and 12 for specifics.* *(7-1-06)T*

595. ICF/MR - COMPENSATION OF RELATED PERSONS.
Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. (7-1-06)T

01. Compensation Claimed. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. (7-1-06)T

a. Where such persons perform services without pay, no cost may be imputed. (7-1-06)T

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. (7-1-06)T

c. Compensation for undocumented hours worked will not be a reimbursable cost. (7-1-06)T

02. Related Persons. A related person is defined as having one (1) of the following relationships with the provider: (7-1-06)T

a. Husband or wife; (7-1-06)T

b. Son or daughter or a descendent of either; (7-1-06)T

c. Brother, sister, stepbrother, stepsister or descendent thereof; (7-1-06)T

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; (7-1-06)T

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; (7-1-06)T

f. A descendent of a brother or sister of the provider's father or mother; (7-1-06)T

g. Any other person with whom the provider does not have an arms length relationship. (7-1-06)T

596. ICF/MR - INTEREST EXPENSE.
Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. (7-1-06)T

597. ICF/MR - IDAHO OWNER-ADMINISTRATIVE COMPENSATION.
Allowable compensation to owners and persons related to owners who provide any administrative services will be limited based on the schedule in this **s**ection. (7-1-06)T

01. Allowable Owner Administrative Compensation. The following schedule will be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, ~~*1996*~~ *2002*.

Licensed Bed Range	Upper limit
51 - 100	86,951
101 - 150	95,641
151 - 250	129,878
251 - up	186,435

~~*(7-1-06)T*~~(7-1-06)T

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section will be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by Data Resources Incorporated, its successor organization or, if unavailable, another nationally recognized forecasting firm. (7-1-06)T

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 597.01. of these rules. Allowable compensation will be determined as follows: (7-1-06)T

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services will be counted, regardless of whether they are in the same facility. (7-1-06)T

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation. (7-1-06)T

c. For owners providing services to less than fifty-one (51) beds, such services

related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and will be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service will be documented. In no event will the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 597.01 of these rules. (7-1-06)T

04. Compensation for Persons Related to an Owner. Compensation for persons related to an owner will be evaluated in the same manner as for an owner. (7-1-06)T

05. When an Owner Provides Services to More Than One Provider. When an owner provides services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for non-owners. (7-1-06)T

06. More Than One Owner or Related Party May Receive Compensation for Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured will be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and will not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, will not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080). (7-1-06)T

598. -- 599. (RESERVED).

600. ICF/MR - OCCUPANCY ADJUSTMENT FACTOR.
In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows: (7-1-06)T

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Section ~~*004*~~ *013* of these rules. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs. ~~*(7-1-06)T*~~(7-1-06)T

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been

converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. (7-1-06)T

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories. (7-1-06)T

04. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. (7-1-06)T

05. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. (7-1-06)T

601. ICF/MR - RECAPTURE OF DEPRECIATION.
Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. (7-1-06)T

01. Amount Recaptured. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken. (7-1-06)T

02. Time Frame. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. (7-1-06)T

602. ICF/MR - REPORTING SYSTEM.
The objective of the reporting requirements is to provide a uniform system of periodic reports which will allow: (7-1-06)T

01. Basis for Reimbursement. A basis of provider reimbursement approximating actual costs. (7-1-06)T

02. Disclosure. Adequate financial disclosure. (7-1-06)T

03. Statistical Resources. Statistical resources, as a basis for measurement of

reasonable cost and comparative analysis. (7-1-06)T

04. **Criteria**. Criteria for evaluating policies and procedures. (7-1-06)T

603. ICF/MR - REPORTING SYSTEM PRINCIPLE AND APPLICATION.
The provider will be required to file mandatory annual cost reports. (7-1-06)T

01. **Cost Report Requirements**. The fiscal year end cost report filing must include: (7-1-06)T

a. Annual income statement (two (2) copies); (7-1-06)T

b. Balance sheet; (7-1-06)T

c. Statement of ownership; (7-1-06)T

d. Schedule of patient days; (7-1-06)T

e. Schedule of private patient charges; (7-1-06)T

f. Statement of additional charges to residents over and above usual monthly rate; and (7-1-06)T

g. Other schedules, statements, and documents as requested. (7-1-06)T

~~***02.*** ***Cost Statement Requirements****. Quarterly and short period cost statement filings must include:* *(7-1-06)T*~~

~~***a.*** *Filed not later than sixty (60) days after the close of the period. Reports received after this time will be accepted at the option of the Department.* *(7-1-06)T*~~

~~***b.*** *Statement of current costs to include at least one (1) quarter (or adjusted quarter, if applicable). Statement may also be filed for any period beginning and ending with quarters of the provider's fiscal year. Other reporting period may be requested.* *(7-1-06)T*~~

~~***c.*** *Schedule of patient days.* *(7-1-06)T*~~

~~***d.*** *Schedule of all patient charges.* *(7-1-06)T*~~

~~***e.*** *Other schedules, statements, and clarifications as requested.* *(7-1-06)T*~~

0~~*3*~~2. **Special Reports**. Special reports may be required. Specific instructions will be issued, based upon the circumstance. (7-1-06)T

0~~*4*~~3. **Criteria of Reports**. All reports must meet the following criteria: (7-1-06)T

a. State approved formats must be used. (7-1-06)T

b. Presented on accrual basis. (7-1-06)T

c. Prepared in accordance with generally accepted accounting principles and principles of reimbursement. (7-1-06)T

d. Appropriate detail must be provided on supporting schedules or as requested. (7-1-06)T

0~~5~~4. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant. (7-1-06)T

0~~6~~5. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. (7-1-06)T

0~~7~~6. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements will be met: (7-1-06)T

a. Outgoing management or administration will file an adjusted-period cost report if it is necessary. This report will meet the criteria for annual cost reports, except that it will be filed not later than sixty (60) days after the change in management or ownership. (7-1-06)T

b. The Department may require an appraisal at the time of a change in ownership. (7-1-06)T

0~~8~~7. Reporting Period. When required for establishing rates, new ICF/MR providers will be required to submit cost projections for the first year of operations. ~~*For the remainder of their first year of operations they will be required to file three (3) quarterly costs statements, including one (1) adjusted-quarter report (if applicable), before the annual reporting option may be exercised. If a provider enters the program at some point in mid-quarter, his first quarter reporting dates will be adjusted to reflect not less than two (2) months operation nor more than four (4).*~~ Thereafter, the normal reporting period ~~*would apply*~~ *coincides with the provider's standard fiscal year*. If a provider withdraws from the program and subsequently re-enters, the new provider reporting requirements will apply. ~~*(7-1-06)T*~~(7-1-06)T

604. (RESERVED).

605. ICF/MR - FILING DATES.

01. Deadlines. ~~*Deadlines for filing quarterly cost statements will be sixty (60) days after the close of the quarter so reported.*~~ Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. ~~*(7-1-06)T*~~(7-1-06)T

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. (7-1-06)T

606. ICF/MR - FAILURE TO FILE.
Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's interim rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. (7-1-06)T

607. ICF/MR - ACCOUNTING SYSTEM.
Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. (7-1-06)T

608. -- 609. (RESERVED).

610. ICF/MR - AUDITS.
~~*The objectives of an audit are that*~~ All financial reports are subject to audit by Departmental representatives ~~*as described in Sections 610 through 612 of these rules*~~. ~~*(7-1-06)T*~~(7-1-06)T

01. Accuracy of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (7-1-06)T

02. Reliability of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results of the to the provider's operations. (7-1-06)T

03. Economy and Efficiency. To determine if Title XIX and Title XXI participants have received the required care on the a basis of economy and efficiency. (7-1-06)T

04. Application of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (7-1-06)T

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding his fiduciary responsibilities for patients, funds and property. (7-1-06)T

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (7-1-06)T

07. Compliance. To provide recommendations which will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program

participants. (7-1-06)T

08. Final Settlement. To effect final settlement when required by Sections 587 through 632 of these rules. (7-1-06)T

611. ICF/MR - AUDIT APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year. (7-1-06)T

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. (7-1-06)T

03. Additional Audits. In addition, audits may be required where: (7-1-06)T

a. A significant change of ownership occurs. (7-1-06)T

b. A change of management occurs. (7-1-06)T

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. (7-1-06)T

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. (7-1-06)T

612. ICF/MR - AUDIT STANDARDS AND REQUIREMENTS.

01. Review of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. (7-1-06)T

02. Requirements. Providers Reimbursement Manual (PRM), Section 2404.3 states: “Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary. (7-1-06)T

03. Examination of Records. Examination of records and documents may include: (7-1-06)T

a. Corporate charters or other documents of ownership including those of a parent or related companies. (7-1-06)T

b. Minutes and memos of the governing body including committees and its agents. (7-1-06)T

c. All contracts. (7-1-06)T

d. Tax returns and records, including workpapers and other supporting documentation. (7-1-06)T

e. All insurance contracts and policies including riders and attachments. (7-1-06)T

f. Leases. (7-1-06)T

g. Fixed asset records (see audit section - Capitalization of Assets). (7-1-06)T

h. Schedules of patient charges. (7-1-06)T

i. Notes, bonds and other evidences of liability. (7-1-06)T

j. Capital expenditure records. (7-1-06)T

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. (7-1-06)T

l. Evidence of litigations the facility and its owners are involved in. (7-1-06)T

m. Documents of ownership including attachments which describe the property. (7-1-06)T

n. All invoices, statements and claims. (7-1-06)T

o. Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit work papers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request, under PRM, paragraph 2404.4(Q). (7-1-06)T

p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (7-1-06)T

q. All patient records, including trust funds and property. (7-1-06)T

r. Time studies and other cost determining information. (7-1-06)T

s. All other sources of information needed to form an audit opinion. (7-1-06)T

04. Adequate Documentation. (7-1-06)T

a. Adequate cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to ~~*beneficiaries*~~ *participants*. This includes all ledgers, books, records and original evidences of cost including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, and other documentation which pertains to the

determination of reasonable cost, capable of being audited under PRM, Section 2304. ~~(7-1-06)T~~(7-1-06)T

b. Adequate expenses documentation including an invoice, or a statement with invoices attached which support the statement. All invoices should meet the following standards: (7-1-06)T

i. Date of service or sale; (7-1-06)T

ii. Terms and discounts; (7-1-06)T

iii. Quantity; (7-1-06)T

iv. Price; (7-1-06)T

v. Vendor name and address; (7-1-06)T

vi. Delivery address if applicable; (7-1-06)T

vii. Contract or agreement references; and (7-1-06)T

viii. Description, including quantity, sizes, specifications brand name, services performed. (7-1-06)T

c. Capitalization of assets for major movable equipment will be capitalized. Minor movable equipment cannot be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. (7-1-06)T

d. Completed depreciation records must meet the following criteria for each asset: (7-1-06)T

i. Description of the asset including serial number, make, model, accessories, and location. (7-1-06)T

ii. Cost basis should be supported by invoices for purchase, installation, etc. (7-1-06)T

iii. Estimated useful life. (7-1-06)T

iv. Depreciation method such as straight line, double declining balance, etc. (7-1-06)T

v. Salvage value. (7-1-06)T

vi. Method of recording depreciation on a basis consistent with accounting policies. (7-1-06)T

vii. Report additional information, such as additional first year depreciation, even

though it isn't an allowable expense. (7-1-06)T

viii. Reported depreciation expense for the year and accumulated depreciation will tie to the asset ledger. (7-1-06)T

e. Depreciation methods such as straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (7-1-06)T

f. The depreciable life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, ~~*1993*~~ *2004* revised edition. Guidelines Lives, which is hereby incorporated by reference into these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. ~~*(7-1-06)T*~~(7-1-06)T

g. Lease purchase agreements may generally be recognized by the following characteristics: (7-1-06)T

i. Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (7-1-06)T

ii. Intent to create security interest; (7-1-06)T

iii. Lessee may acquire title through exercise of purchase option which requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (7-1-06)T

iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and (7-1-06)T

v. Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (7-1-06)T

h. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. (7-1-06)T

i. Complete personnel records containing the following: (7-1-06)T

i. Application for employment. (7-1-06)T

ii. W-4 Form. (7-1-06)T

iii. Authorization for other deductions such as insurance, credit union, etc. (7-1-06)T

iv. Routine evaluations. (7-1-06)T

v. Pay raise authorization. (7-1-06)T

vi. Statement of understanding of policies, procedures, etc. (7-1-06)T

vii. Fidelity bond application (where applicable). (7-1-06)T

05. Internal Control. (7-1-06)T

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (7-1-06)T

i. Safeguarding assets and resources against waste, fraud, and inefficiency. (7-1-06)T

ii. Promoting accuracy and reliability in financial records. (7-1-06)T

iii. Encouraging and measuring compliance with company policy and legal requirements. (7-1-06)T

iv. Determining the degree of efficiency related to various aspects of operations. (7-1-06)T

b. An adequate system of internal control over cash disbursements would normally include: (7-1-06)T

i. Payment on invoices only, or statements supported by invoices. (7-1-06)T

ii. Authorization for purchase such as a purchase order. (7-1-06)T

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (7-1-06)T

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (7-1-06)T

v. Check of invoice accuracy. (7-1-06)T

vi. Approval policy for invoices. (7-1-06)T

vii. Method of invoice cancellation to prevent duplicating payment. (7-1-06)T

viii. Adequate separation of duties between ordering, recording, and paying. (7-1-06)T

ix. System separation of duties between ordering, recording, and paying. (7-1-06)T

x. Signature policy. (7-1-06)T

xi. Pre-numbered checks. (7-1-06)T

xii. Statement of policy regarding cash or check expenditures. (7-1-06)T

xiii. Adequate internal control over the recording of transactions in the books of record. (7-1-06)T

xiv. An imprest system for petty cash. (7-1-06)T

06. Accounting Practices. Sound accounting practices normally include the following: (7-1-06)T

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (7-1-06)T

b. Chart of accounts. (7-1-06)T

c. A budget or operating plan. (7-1-06)T

613. ICF/MR - PATIENT FUNDS.
The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. (7-1-06)T

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (7-1-06)T

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (7-1-06)T

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (7-1-06)T

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or his agent in writing. (7-1-06)T

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (7-1-06)T

03. Fund Management. Proper management of such funds would include the following as minimum: (7-1-06)T

a. Savings accounts, maintained separately from facility funds. (7-1-06)T

b. An accurate system of supporting receipts and disbursements to patients.

(7-1-06)T

c. Written authorization for all deductions. (7-1-06)T

d. Signature verification. (7-1-06)T

e. Deposit of all receipts of the same day as received. (7-1-06)T

f. Minimal funds kept in the facility. (7-1-06)T

g. As a minimum these funds must be kept locked at all times. (7-1-06)T

h. Statement of policy regarding patient's funds and property. (7-1-06)T

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (7-1-06)T

j. System of periodic review and correction of policies and financial records of patient property and funds. (7-1-06)T

614. (RESERVED).

615. ICF/MR - POST-ELIGIBILITY TREATMENT OF INCOME.

01. Treatment of Income. Where an individual is determined eligible for medical assistance participation in the cost of his long term care, the Department must reduce its payment to the long term care facility by the amount of his income considered available to meet the cost of his care. This determination is made in accordance IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Sections 721 through 725. (7-1-06)T

02. SSA Income. The amount which the Participant receives from SSA as reimbursement for his payment of the premium for Part B of Title XVIII (Medicare) is not considered income for participant liability in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)." (7-1-06)T

616. -- 619. (RESERVED).

620. ICF/MR - PAYMENTS FOR PERIODS OF TEMPORARY ABSENCE.
Payments may be made for reserving beds in ICFs/MR for participants during their temporary absence if the facility charges private paying participants for reserve bed days, subject to the following limitations: (7-1-06)T

01. Prior Approval for Absence. Therapeutic home visits for ICF/MR residents of up to thirty-six (36) days per calendar year so long as the days are part of a written treatment plan ordered by the attending physician. Prior approval from the RMS must be obtained for any home visits exceeding fourteen (14) consecutive days. (7-1-06)T

02. Limits on Amount of Payments. Payment for reserve bed days will be lesser of

the following: (7-1-06)T

a. One hundred percent (100%) of the audited allowable costs of the facility; or (7-1-06)T

b. The rate charged to private paying participants for reserve bed days. (7-1-06)T

621. ICF/MR - PAYMENT PROCEDURES.
Each ICF/MR must submit its claims to the Department in accordance with the procedures established by the Department. The Department will not pay for a claim in behalf of a Participant unless the information on the claim is consistent with the information in the Department's computer eligibility file. (7-1-06)T

622. ICF/MR - PRINCIPLE PROSPECTIVE RATES.
Providers of ICF/MR facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider will report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/MR providers. Total payment will include the following components: Property reimbursement, capped costs, an efficiency increment, exempt costs, excluded costs. (7-1-06)T

623. ICF/MR - PROPERTY REIMBURSEMENT.
Beginning October 1, 1996, ICF/MR property costs are reimbursed by a rental rate or based on cost. The following will be reimbursed based on cost as determined by the provisions of this chapter and applicable provisions of PRM to the extent not inconsistent with this chapter: ICF/MR living unit property taxes, ICF/MR living unit property insurance, and major movable equipment not related to home office or day treatment services. Reimbursement of other property costs is included in the property rental rate. Any property cost related to home offices and day treatment services are not considered property costs and will not be reported in the property cost portion of the cost report. These costs will be reported in the home office and day treatment section of the cost report. Property costs, including costs which are reimbursed based on a rental rate, will be reported in the property cost portion of the cost report. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. Property costs include the following components: (7-1-06)T

01. Depreciation. Allowable depreciation based on straight line depreciation. (7-1-06)T

02. Interest. All allowable interest expense which relates to financing depreciable assets. Interest on working capital loans is not a property cost and is subject to the cap. (7-1-06)T

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances are not property costs. (7-1-06)T

04. Lease Payments. All allowable lease or rental payments. (7-1-06)T

05. Property Taxes. All allowable property taxes. (7-1-06)T)

06. Costs of Related Party Leases. Costs of related party leases are to be reported in the property cost categories based on the owner's costs. (7-1-06)T

624. ICF/MR - CAPPED COST.
Beginning October 1, 1996, this cost area includes all allowable costs except those specifically identified as property costs in Section 623 of these rules and exempt costs or excluded costs in Section 627 or 628 of these rules. This Section defines items and procedures to be followed in determining allowable and exempt costs and provides the procedures for extracting cost data from historical cost reports, applying a cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the median of the range of costs and the ICF/MR cap. (7-1-06)T

01. Costs Subject to the Cap. Items subject to the cap include all allowable costs except property costs identified in Section 623 of these rules and exempt costs or excluded costs identified in Section 627 or 628 of these rules. Property costs related to a home office are administrative costs, will not be reported as property costs, and are subject to the cap. (7-1-06)T

02. Per Diem Costs. Costs to be included in this category will be divided by the total participant days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid residents are not included in the total costs submitted, the provider must determine the costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for both the purposes of determining the ICF/MR cap and of computing final reimbursement. (7-1-06)T

03. Cost Data to Determine the Cap. Cost data to be used to determine the cap for ICF/MR facilities will be taken from each provider's most recent final cost report available sixty (60) days before the beginning of the period for which the cap is being set. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. The selected final cost report will be used to establish the facility's prospective reimbursement rate. However, the final cost reports covering a period of less than twelve (12) months will be included in the data for determining the cap at the option of the Department. (7-1-06)T

04. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the same table as used for free standing facilities. (7-1-06)T

a. The projection method used in Section 624 of these rules to set the cap will also be used to set non property portions of the prospective rate which are not subject to the cap. (7-1-06)T

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used. (7-1-06)T

05. Costs Which Can be Paid Directly by the Department to Non ICF/MR

Providers. Costs which can be paid directly by the Department to non ICF/MR providers are excluded from the ICF/MR prospective rates and ICF/MR cap: (7-1-06)T

a. Direct physician care costs. Physicians who provide these services must bill the Medicaid program directly using their own provider numbers. (7-1-06)T

b. Costs of services covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) portion of the Medicaid Program. These services are enumerated in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and include such items and services as eyeglasses, hearing aids, and dental services provided to Medicaid participants under the age of twenty-one (21). The cost of these services is not includable as a part of ICF/MR costs. Reimbursement can be made to a professional providing these services through his billing the Medicaid Program on his own provider number. (7-1-06)T

c. Costs of services covered by other parts of the Medicaid Program. Examples of these items include legend drugs and ambulance transportation. These items must be billed to the Medicaid Program directly by the provider using his own provider number. (7-1-06)T

06. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the Base Period to the midpoint of the Target Period. "Base Period" is defined as the last available final cost report period. "Target Period" is defined as the effective period of the prospective rate. Procedures for inflating these costs are as follows: (7-1-06)T

a. The percentage change for each cost category in the market basket will be computed from the beginning to the end of the Base Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint to the end of the Base Period. (7-1-06)T

b. The percentage change for each cost category in the market basket will be computed for the period from the end of the Base Period to the beginning of the Target Period. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 624.06.a. of these rules, from the end of the Base Period to the beginning of the Target Period. (7-1-06)T

c. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the Target Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 624.06.b. of these rules from the beginning to the midpoint of the Target Period. (7-1-06)T

07. Cost Ranking. Prior to October 1st of each year the Director will determine the that percent above the median which will assure aggregate payments to ICF/MR providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30th of each year. Projected per diem costs as determined in this section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996. (7-1-06)T

a. The median of the range will be computed based on the available data points being considered as the total population of data points. (7-1-06)T

b. The cap for each ICF/MR facility with a fiscal year beginning October 1, 1996, will be computed prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30th, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date. (7-1-06)T

c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions of Section 626 of these rules apply. (7-1-06)T

d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter. (7-1-06)T

e. A new cap and rate will be set *on an annual basis* for each facility~~*'s fiscal year after September 30, 1996*~~ *the first of July every year*. ~~*(7-1-06)T*~~(7-1-06)T

f. The cap and prospective rate will be determined and set *on an annual basis* for each facility~~*'s upcoming fiscal year prior to that year and it*~~ *July first of every year and* will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures. ~~*(7-1-06)T*~~(7-1-06)T

g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section 628 of these rules apply. (7-1-06)T

h. A facility which commences to offer participant care services as an ICF/MR on or after October 1, 1996, will be subject to retrospective settlement until the first prospective rate is set. Such facility will be subject to the ICF/MR cap as determined in this chapter. The first prospective rate for this provider will be set by the Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3) months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period. (7-1-06)T

625. ICF/MR - EFFICIENCY INCREMENT.

An efficiency increment will be included as a component of the prospective rate, or retrospective settlement if the allowable capped per diem costs are less than the cap. (7-1-06)T

01. Computing Efficiency Increment. The efficiency increment will be computed by subtracting the projected or, for facilities subject to retrospective settlement the actual allowable per diem costs incurred by the provider, from the applicable cap. This difference will be divided by five (5). The allowable increment is twenty cents ($.20) per one dollar ($1) below the cap up to a maximum increment of three dollars ($3) per participant day. (7-1-97)

02. Determining Reimbursement. Total reimbursement determined by adding amounts determined to be allowable, will not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and PRM. In computing participant days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the participant is making payment for holding a bed in the facility, the participant will not be considered to be discharged and thus those days will be counted in the total. (7-1-06)T

626. ICF/MR - RETROSPECTIVE SETTLEMENT.
When retrospective settlement is applicable, it is based on allowable reimbursement in accordance with this chapter and based on an audit report. Retrospective settlement will be subject to the same caps and limits determined for prospective payments. (7-1-06)T

01. A Provider's Failure to Meet Any of the Conditions. A provider's failure to meet any of the conditions of participation set forth in 42 CFR 483, Subpart I, may subject that provider to retrospective reimbursement for the fiscal year, or any portion thereof, during which the condition is not met. The provider's projected per diem rate may be adjusted to reflect actual reimbursable costs subject to cost limits. (7-1-06)T

02. A First Time Provider. A first time provider operating a new ICF/MR living unit will be subject to a retrospective settlement for the first fiscal year and until the first subsequent period wherein a prospective rate is set in accordance with Sections 603, 605, and 606 of these rules and this chapter. A budget based on the best available information is required prior to opening for participant care so an interim rate can be set. (7-1-06)T

03. New ICF/MR Living Unit. A new ICF/MR living unit for an existing operator is subject to first time facility requirements if the new living unit reflects a net increase in licensed beds, otherwise the Department may set a prospective rate with the non-property rate components based on similar components of rates most recently paid for the participants moving into the facility. The property rental rate will be set according to applicable provisions of this chapter. (7-1-06)T

04. Change of Ownership of Existing ICF/MR Living Unit. Where there is a change of ownership of an existing ICF/MR living unit, the provider operating the ICF/MR living unit will not receive an adjustment of the provider's prospective rate except that the property rental portion of the rate will be adjusted subject to property rental provisions of this chapter. However, new facility reporting requirements and the cap will apply. (7-1-06)T

05. Fraudulent or False Claims. Providers who have made fraudulent or false claims are subject to retrospective settlement as determined by the Department. (7-1-06)T

06. Excluded Costs. Excluded costs may be retrospectively settled according to the provisions of Section 247 of these rules. (7-1-06)T

627. ICF/MR - EXEMPT COSTS.
Exempt costs are not subject to the ICF/MR cap. (7-1-06)T

01. Day Treatment Services. As specified in this Section, the cost of day treatment

services may be reimbursed in this category and may not be subject to the ICF/MR cap.(7-1-06)T

a. This category includes the direct costs of labor, benefits, contracted services, property, utilities and supplies for such services up to the limitations provided in this Subsection. (7-1-06)T

b. When a school or another agency or entity is responsible for or pays for services provided to a participant regularly during normal working hours on weekdays, no costs will be assigned to this category for such services. The Department will not reimburse for the cost of services which are paid for or should be paid for by an other agency. (7-1-06)T

c. When ICF/MR day treatment services are performed for participants in a licensed Developmental Disability Center, the allowable cost of such services will be included in this category, but not more than the amount that would be paid according to the Department's fee schedule for individual or group therapy for similar services. Amounts incurred or paid by the ICF/MR in excess of what would be paid according to the Department's fee schedule for like services are not allowable costs and will be reported as non-reimbursable. (7-1-06)T

d. For day treatment services provided in a location other than a certified developmental disability center, the maximum amount reportable in this category will also be limited. Total costs for such services reported by each provider in this category will be limited to the number of hours, up to thirty (30) hours per week per participant, of individual or group developmental therapy times the hourly rate that would be paid according to the most recent Department fee schedule for the same services if provided in a developmental disability center. Costs in excess of the limits determined in this Subsection will be classified and reported as subject to the ICF/MR cap. Initial rates established under the prospective system effective October 1, 1996, and not later than October 1, 1997, will not include a limitation of day treatment costs based on the hourly rate, when the hours of individual or group therapy were not obtained or audited by the Department at the time the rate was published. However, if a provider believes that the day treatment cost used to establish the day treatment portion of its prospective rate was misstated for rates set for periods beginning October 1, 1996, through rates beginning October 1, 1997, revisions to the prospective rate may be made to the extent the provider demonstrates, to the satisfaction of the Department, that the cost used was misstated. Such a revision will be considered only if the provider requests a revision and provides adequate documentation within sixty (60) days of the date the rate was set. At the option of the Department it may negotiate fixed rates for these day treatment services. Such rates will be set so the aggregate related payments are lower than would be paid with a limitation based on schedules used for licensed Developmental Disability Centers. (7-1-06)T

e. Financial data including expenses and labor hours incurred by or on behalf of the provider in providing day treatment services, must be identifiable and separate from the costs of other facility operations. Reasonable property costs related to day treatment services and not included in the property rental rate, will be separately identified, will be reported as day treatment services costs, and will not include property costs otherwise reimbursed. Property costs related to day treatment services will be separately identified as not related to living unit costs by a final audit determination issued prior to October 1, 1996, or will be separate and distinct from any property used for ICF/MR services which are or were day treatment services. (7-1-06)T

f. In the event a provider has a change in the number of participants requiring day treatment services, the prospective rate may be adjusted by the Department to reflect a change in costs related to such a change. Providers receiving such changes may be required to provide added documentation to the Department to assure that further changes can be identified and the prospective rate adjusted accordingly. (7-1-06)T

02. Major Movable Equipment. Costs related to major movable equipment, as defined in this chapter will be exempt from the ICF/MR cap and will be reimbursed prospectively based on Medicare principles of cost reimbursement. (7-1-06)T

628. ICF/MR - COSTS EXCLUDED FROM THE CAP.
Certain costs may be excluded from the ICF/MR cap, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rate as provided in this Section to assure equitable reimbursement: (7-1-06)T

01. Increases of More Than One Dollar Per Participant Day in Costs. Increases of more than one dollar ($1) per participant day in costs otherwise subject to the cap incurred by a facility as a result of changes in State or Federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the cap. The Department may adjust the forecasted rate to include the projected per diem related to such costs. (7-1-06)T

a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. (7-1-06)T

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately. (7-1-06)T

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (7-1-06)T

d. For interim rate purposes the provider's prospective rate may be granted an increase to cover such cost increases. A cost statement covering a recent period may be required with the justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (7-1-06)T

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases with costs subject to the cap when setting rates or increase the cap and individual facility prospective rates following such cost increases. If a cap is set with these particular costs included in the cap category, providers subject to that cap will not have these costs excluded from the cap for prospective rate purposes. The intent of this provision is for costs to be exempt from

the cap until these costs are able to be fully and equitably incorporated in the data base used to project the cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted. (7-1-06)T

f. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cap, the cost indices will be adjusted to exclude the influence of such changes if the amount is included in the index is identified. When the cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed. (7-1-06)T

02. Excess Inflation. Reimbursement of costs subject to the cap will be limited to the cap unless the Department determines the inflation indices used to set the prospective rates for a reporting period understated actual inflation by more than seven (7%) percentage points. In such case, prospective rates and the cap will be increased by the amount which actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the department. (7-1-06)T

03. Cost Increases Greater Than Three Percent. When cost increases of greater than three percent (3%) of the projected interim rate which result from disasters such as fire, flood, or earthquake, epidemic or similar unusual and unpredictable circumstances over which a provider has no control. Prospective rates will be increased and they will not be subject to the cap. However, they may be retrospectively adjusted by the Department. For the purposes of this Subsection, disaster does not include personal or financial problems. (7-1-06)T

04. Decreases. In the event of state or federal law, rule, or policy changes which result in clearly identifiable reductions in required services, the Department may reduce the prospective rate to reflect the identified per diem amount related to such reductions. (7-1-06)T

05. Prospective Negotiated Rates. Notwithstanding the provisions of Section 622 of these rules, the Director will have the authority to negotiate prospective rates for providers who would otherwise be subject to accept retrospective settlement. Such rates will not exceed the projected allowable rate that would otherwise be reimbursed based on provisions of this chapter. (7-1-06)T

629. ~~(RESERVED)~~ICF/MR - LEGAL CONSULTANT FEES AND LITIGATION COSTS.

Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the following: (7-1-06)T

***01. In General**. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare, will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days. (7-1-06)T*

***02. Administrative Appeals**. In the case of the provider contesting in administrative appeal the findings of an audit performed by the Department of Health and Welfare, the costs of*

the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The determination of the extent that the provider prevails will be based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator. *(7-1-06)T*

03. ***Other****: All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law.* *(7-1-06)T*

630. ICF/MR - PROPERTY RENTAL RATE REIMBURSEMENT.
ICFs/MR will be paid a property rental rate. Property taxes*,* ~~*and*~~ property insurance*, and depreciation expense or major moveable equipment* will be reimbursed as costs exempt from limitations. The property rental rate ~~*includes*~~ *does not include* compensation for ~~*major movable equipment but not for*~~ minor movable equipment. ~~*However, the property rental rate for ICF/MR will not include compensation for major movable equipment.*~~ The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. See Sections 56-108 and 56-109, Idaho Code, for further clarification.
~~*(7-1-06)T*~~(7-1-06)T

01. Property Rental Rate. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to the following: (7-1-06)T

a. R = "Property Base" x 40 - "Age" / 40 x "change in building costs" where: (7-1-06)T

b. "R" = the property rental rate. (7-1-06)T

c. "Property Base" = ~~*thirteen dollars and nineteen cents ($13.19) beginning October 1, 1996 for all freestanding nursing facilities but not ICF/MR facilities. Beginning October 1, 1996, the property base rate for ICF/ MR - living units will be*~~ eleven dollars and twenty-two cents ($11.22) except for ICF/MR living units not able to accommodate residents requiring wheelchairs *beginning October 1, 1996*. Property base = seven dollars and twenty-two cents ($7.22) for ICF/ MR living units not able to accommodate residents requiring wheelchairs.
~~*(7-1-06)T*~~(7-1-06)T

d. "Change in building costs" = 1.0 from October 1, 1996, through December 31, 1996. ~~*Beginning January 1, 1997, "change in building costs" will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs whichever is greater. For freestanding nursing facilities, the index available in September of the prior year will be used; f*~~For ICF/MR facilities, the most recent index available when it is first necessary to set a prospective rate for a period that includes all or part of the calendar year, will be used. ~~*(7-1-06)T*~~(7-1-06)T

e. "Age" of facility - The effective age of the facility in years will be set by

subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof will be assigned an age of more than thirty (30) years, however: (7-1-06)T

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age will be set at thirty (30) years. Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness. An age will be determined for each building. A weighted average using the age and square footage of the buildings will become the effective age of the facility. The age of each building will be based upon the date when construction on that building was completed. This age will be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula:

$$r = A \times E / S \times C$$

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 630.01.d.ii.

If the result of this calculation, “r” is equal to or greater than two point zero (2.0), the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0). (7-1-06)T

ii. For rates paid after June 30, 1989, the effective age of a facility will be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 630.01.d.i. However, such change will not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate “r” for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for “C” will be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider's responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs. (7-1-06)T

iii. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department

will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility. (7-1-06)T

iv. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 630.01.d.iii. and 630.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of the financial burden to the state of subsequent property rate increases for a current or successor provider. (7-1-06)T

v. Effective October 1, 1996, for ICF/ MR facilities, "age of facility" will be a revised age which is the lesser of the age established under other provisions of this Section or the age which most closely yields the rate allowable to existing facilities as of ~~*June 30, 1991*~~ *September 30, 1996*, under Subsection 630.01 of these rules. This revised age will not increase over time. ~~*(7-1-06)T*~~(7-1-06)T

02. Sale of a Facility. In the event of the sale of a facility, or asset of a facility, the buyer will receive the property rental rate of Subsection 630.01 of these rules~~*, except in the event of a forced sale or except in the event of a first sale of a facility receiving a "grandfathered rate" after June 30, 1991, whereupon the property rental rate of the new owner will be computed as if no sale had taken place*~~. ~~*(7-1-06)T*~~(7-1-06)T

~~***03. Forced Sale of a Facility**. In the event of a forced sale of a facility, or asset of a facility, where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon his incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total participant days for that period, or the property rental rate, whichever is higher, but not exceeding the rate that would be due the seller.*~~ ~~*(7-1-06)T*~~

631. ICF/MR - PROPERTY REIMBURSEMENT LIMITATIONS.
Beginning October 1, 1996, property costs of an ICF/MR will be reimbursed in accordance with S~~*ubs*~~ection ~~*587.15*~~ *630* of these rules except as follows: ~~*(7-1-06)T*~~(7-1-06)T

01. Restrictions. No grandfathered rates or lease provisions other than lease provisions in Section 630 of these rules will apply to ICF/MR facilities. (7-1-06)T

02. Home Office and Day Treatment Property Costs. Distinct parts of buildings containing ICF/MR living units may be used for home office or day treatment purposes. Reimbursement for the property costs of such distinct parts may be allowed if these areas are used exclusively for home office or day treatment services. The portion of property cost attributed to these areas may be reimbursed as part of home office or day treatment costs without a reduction in the property rental rate. Reimbursement for home office and day treatment property costs will not include costs reimbursed by, or covered by the property rental rate. Such costs will only be

reimbursed as property cost if the facility clearly included space in excess of space normally used in such facilities. At a minimum to qualify for such reimbursement, a structure would have square feet per licensed bed in excess of the average square feet per licensed bed for other ICF/MR living units within four (4) licensable beds. (7-1-06)T

03. Leases for Property. Beginning October 1, 1996, ICF/MR facilities with leases will be reimbursed as follows: (7-1-06)T

a. The property costs related to ICF/MR living units other than costs for major movable equipment will be paid by a property rental rate in accordance with Section 0630 of these rules. (7-1-06)T

b. Leases for property other than ICF/MR living units will be allowable based on lease cost to the facility not to exceed a reasonable market rate, subject to other provisions of this chapter, and PRM principles including principles associated with related party leases. (7-1-06)T

632. ICF/MR - SPECIAL RATES.
Section 56-117, Idaho Code, provides that the Department may pay facilities a special rate for care given to consumers who have medical or behavior long-term care needs beyond the normal scope of facility services. These individuals must have one (1) or more of the following behavior needs; additional personnel for supervision, additional behavior management, or additional psychiatric or pharmacology services. A special rate may also be given to consumers having medical needs that may include but are not limited to individuals needing ventilator assistance, certain medical pediatric needs, or individuals requiring nasogastric or intravenous feeding devices. These medical and behavior needs are not adequately reflected in the rates calculated pursuant to the principles set in Section 56-113, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter and will be based on a per diem rate applicable to the incremental additional costs incurred by the facility. Payment for special rates will start with approval by the Department and be and reviewed at least yearly for continued need. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of Section 632 of these rules, will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-06)T

01. Determinations. A determination to approve or not approve a special rate will be made on a consumer-by-consumer basis. No rate will be allowed if reimbursement for these needs is available from a non- Medicaid source. (7-1-06)T

02. Approval. Special rates will not be paid unless prior authorized by the Department. A special rate may be used in the following circumstances: (7-1-06)T

a. New admissions to a community ICF/MR; (7-1-06)T

b. For individuals currently living in a community ICF/MR when there has been a significant change in condition not reflected in the current rate; or (7-1-06)T

c. The facility has altered services to achieve and maintain compliance with state

licensing or federal certification requirements that have resulted in additional cost to the facility not reflected in their current rate. (7-1-06)T

d. For the purpose of this rule, an emergency exists when the facility must incur additional behavioral or medical costs to prevent a more restrictive placement. (7-1-06)T

03. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. (7-1-06)T

04. Limitations. The reimbursement rate paid will not exceed the provider's charges to other participants for similar services. (7-1-06)T

633. REIMBURSEMENT PROVISIONS FOR STATE OWNED OR OPERATED ICF/MR FACILITIES.
Provisions of these rules do not apply to ICF/MR facilities owned or operated by the state of Idaho. Reimbursement of such facilities will be governed by the principles set forth in the PRM, with the exception of depreciation. Assets of such facilities need not be depreciated if they have an acquisition or historical cost of less than five thousand dollars ($5,000). (7-1-06)T

634. -- 649. (RESERVED).

650. DEVELOPMENTAL DISABILITIES AGENCIES (DDA).
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 certified 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 assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. (7-1-06)T

651. (RESERVED).

652. DEVELOPMENTAL DISABILITIES AGENCY (DDA) SERVICES - ELIGIBILITY.
Prior to receiving services in a DDA an individual must be determined to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code. (7-1-06)T

653. DDA SERVICES - COVERAGE REQUIREMENTS AND LIMITATIONS.

01. Requirement for Plan of Service and Prior Authorization. (7-1-06)T

a. All therapy services for children must be identified on the Individual Program Plan developed by the developmental disabilities agency (DDA) as described in IDAPA 16.04.11,

"Developmental Disabilities Agencies." (7-1-06)T

b. All therapy services for adults with developmental disabilities and ISSH waiver participants must be identified on the plan of service and prior authorized as described in Sections 507 through 520 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (7-1-06)T

02. Assessment and Diagnostic Services. Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation or diagnostic services provided in any calendar year. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies": (7-1-06)T

a. Comprehensive Developmental Assessment; (7-1-06)T

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the twelve (12) hour limitation described in this subsection; (7-1-06)T

c. Occupational Therapy Assessment (7-1-06)T

d. Physical Therapy Assessment; (7-1-06)T

e. Speech and Language Assessment; (7-1-06)T

f. Medical/Social History; and (7-1-06)T

g. Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. (7-1-06)T

03. Therapy Services. Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in IDAPA 16.04.11, "Developmental Disabilities Agencies." The following therapy services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (7-1-06)T

a. Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. (7-1-06)T

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

include: (7-1-06)T

i. Individual psychotherapy; (7-1-06)T

ii. Group psychotherapy; and (7-1-06)T

iii. Family-centered psychotherapy which must include the participant and one (1) other family member at any given time. (7-1-06)T

c. Supportive Counseling. Supportive counseling must only be delivered on an individualized, one to-one basis. Supportive counseling, alone or in combination with psychotherapy services, is limited to a maximum of forty-five (45) hours in a calendar year. (10-1-06)T

d. 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. (7-1-06)T

e. Physical Therapy. Physical therapy services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 730 through 737. Physical therapy includes individual or group therapy. (7-1-06)T

f. Occupational Therapy. Occupational therapy includes individual occupational therapy and group occupational therapy. (7-1-06)T

g. Intensive Behavioral Intervention (IBI). IBI is limited to a lifetime limit of thirty six (36) months. (7-1-06)T

i. The DDA must receive prior authorization from the Department prior to delivering IBI services. (7-1-06)T

ii. IBI must only be delivered on an individualized, one-to-one basis. (7-1-06)T

h. Intensive Behavioral Intervention (IBI) Consultation. IBI consultation is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. (7-1-06)T

i. Collateral Contact. Collateral contact is consultation or treatment direction about the participant to a significant other in the participant's life and may be conducted face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursable. (7-1-06)T

j. Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency and duration of the service specified. The telephoning of prescriptions to the pharmacy

is not a billable service. (7-1-06)T

04. Excluded Services. The following services are excluded for Medicaid payments: (7-1-06)T

a. Vocational services; (7-1-06)T

b. Educational services; and (7-1-06)T

c. Recreational services. (7-1-06)T

05. Limitations on DDA Services. Therapy services may not exceed the limitations as specified below. (7-1-06)T

a. The combination of therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules must not exceed thirty (30) hours per week. (7-1-06)T

b. Therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules provided in combination with Community Supported Employment services under Subsection 703.04 of these rules must not exceed forty (40) hours per week. (7-1-06)T

c. When a HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. (7-1-06)T

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. (7-1-06)T

e. *Prior to delivering any services in a school-based setting, the DDA must have a contract with the school or the Infant Toddler program. The DDA must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856.* *(7-1-06)T*

654. -- 655. (RESERVED).

656. DDA SERVICES - ~~PAYMENT METHODOLOGY~~ PROVIDER REIMBURSEMENT.
Payment for agency services must be in accordance with rates established by the Department. (7-1-06)T

657. -- 660. (RESERVED).

700. INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES/ISSH - WAIVER SERVICES.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to

eligible participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/MR. (7-1-06)T

701. (RESERVED).

702. DD/ISSH WAIVER SERVICES - ELIGIBILITY.
Waiver eligibility will be determined by the Department as described in Section 509 of these rules. The participant must be financially eligible for Medical Assistance as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver participants must meet the following requirements: (7-1-06)T

01. Age of Participants. DD waiver participants must be eighteen (18) years of age or older. ISSH waiver participants must be fifteen (15) years of age through the month of their eighteenth birthday. (7-1-06)T

02. Eligibility Determinations. The Department must determine that: (7-1-06)T

a. The 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 703 of these rules were not made available; and (7-1-06)T

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the person-centered planning team; and prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. (7-1-06)T

c. The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid of ICF/MR care and other medical costs. (7-1-06)

d. Following the approval by the Department for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (7-1-06)T

03. Home and Community Based Services Waiver Eligible Participants. A participant who is determined by the Department to be eligible for services under the Home and Community Based Services Waivers for ISSH and DD may elect to not utilize waiver services but may choose admission to an ICF/MR. (7-1-06)T

04. Processing Applications. The participant's self-reliance staff will process the application in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," as if the application was for admission to an ICF/MR, except that the self-reliance staff will forward potentially eligible applications immediately to the Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (7-1-06)T

05. Transmitted Decisions to Self-Reliance Staff. The decisions of the Department regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. (7-1-06)T

06. Case Redetermination. (7-1-06)T

a. Financial redetermination will be conducted pursuant to IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." Medical redetermination will be made at least annually by the Department, or sooner at the request of the participant, the self-reliance staff, provider agency or physician. The sections cited implement and are in accordance with Idaho's approved State Plan with the exception of deeming of income provisions. (7-1-06)T

b. The redetermination process will assess the following factors: (7-1-06)T

i. The participant's continued need and eligibility for waiver services; and (7-1-06)T

ii. Discharge from the waiver services program. (7-1-06)T

07. Home and Community-Based Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the home and community based waiver for developmentally disabled participants will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th for the DD waiver and after June 30th for the ISSH waiver of each new waiver year. (7-1-06)T

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

01. Residential Habilitation. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (7-1-06)T

a. Habilitation services aimed at assisting the individual to acquire, retain or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (7-1-06)T

i. Self-direction, including the identification of and response to dangerous or

threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (7-1-06)T

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (7-1-06)T

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (7-1-06)T

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (7-1-06)T

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (7-1-06)T

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (7-1-06)T

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (7-1-06)T

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (7-1-06)T

02. Chore Services. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their

provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (7-1-06)T

03. Respite. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers. (7-1-06)T

04. Supported Employment. Supported employment which is competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (7-1-06)T

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or IDEA. (7-1-06)T

b. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (7-1-06)T

05. Transportation. Transportation services which are services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State Plan, defined at 42 CFR 440.170(a), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (7-1-06)T

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent

environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (7-1-06)T

07. Specialized Equipment and Supplies. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the plan of service which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (7-1-06)T

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (7-1-06)T

09. Home Delivered Meals. Home delivered meals which are designed to promote adequate wavier participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. (7-1-06)T

10. Skilled Nursing. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (7-1-06)T

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (7-1-06)T

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

(7-1-06)T

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies." (7-1-06)T

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies." (7-1-06)T

13. Self Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (7-1-06)T

14. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (7-1-06)T

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (7-1-06)T

b. Licensed Intermediate Care Facility for persons with Mental Retardation (ICF/MR); and (7-1-06)T

c. Residential Care or Assisted Living Facility. (7-1-06)T

d. Additional limitations to specific services are listed under that service definition. (7-1-06)T

704. DD/ISSH WAIVER SERVICES - PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All waiver services must be identified on the plan of service and authorized by the process described in Sections 507 through 520 of these rules. The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. (7-1-06)T

02. Provider Records. Three (3) types of record information will be maintained on all participants receiving waiver services: (7-1-06)T

a. Direct Service Provider Information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-06)T

i. Date and time of visit; and (7-1-06)T

ii. Services provided during the visit; and (7-1-06)T

iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (7-1-06)T

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (7-1-06)T

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (7-1-06)T

b. The plan of service developed by the plan developer and the person-centered planning team must specify which services are required by the participant. The plan of service must contain all elements required by Subsection 704.01 of these rules and a copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department. (7-1-06)T

c. In addition to the plan of service, all providers, with the exception of chore, non-medical transportation, and enrolled Medicaid vendors, must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in Sections 507 through 520 of these rules. (7-1-06)T

03. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (7-1-06)T

04. Records Maintenance. In order to provide continuity of services, when a participant changes service providers, plan developers, or service coordinators, all of the foregoing participant records will be delivered to and held by the Department until a replacement service provider, plan developer, or service coordinator is selected by the participant. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. (7-1-06)T

705. DD/ISSH WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES. All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (7-1-06)T

01. Residential Habilitation. Residential habilitation services must be provided by an agency that is certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and is capable of supervising the direct services provided. Individuals who provide residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a Residential Habilitation Agency. The Residential Habilitation Agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide

residential habilitation services in the home of the participant (supported living), must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (7-1-06)T

a. Direct service staff must meet the following minimum qualifications: (7-1-06)T

i. Be at least eighteen (18) years of age; (7-1-06)T

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to an plan of service; (7-1-06)T

iii. Have current CPR and First Aid certifications; (7-1-06)T

iv. ~~*b*~~*B*e free from communicable diseases; ~~*(7-1-06)T*~~(7-1-06)T

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007. (7-1-06)T

~~*i*~~v*i*. 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 individuals eighteen (18) years of age or older living in the home must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06;*~~ ~~*(7-1-06)T*~~(7-1-06)T

~~*v. 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 (7-1-06)T*~~

vi*i*. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (7-1-06)T

b. *All skill training for direct service staff must be provided by a Qualified Mental Retardation Professional (QMRP) who has demonstrated experience in writing skill training programs. (7-1-06)T*

c. *Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (7-1-06)T*

i. Purpose and philosophy of services; (7-1-06)T

ii. Service rules; (7-1-06)T

iii. Policies and procedures; (7-1-06)T

iv. Proper conduct in relating to waiver participants; *(7-1-06)T*

v. Handling of confidential and emergency situations that involve the waiver participant; *(7-1-06)T*

vi. Participant rights; *(7-1-06)T*

vii. Methods of supervising participants; *(7-1-06)T*

viii. Working with individuals with developmental disabilities; and *(7-1-06)T*

ix. Training specific to the needs of the participant. *(7-1-06)T*

~~b~~d. *~~The provider agency will be responsible for providing training specific to the needs of the 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 *be completed within six (6) months of employment or affiliation with the residential habilitation agency and* include at a minimum: *~~(7-1-06)T~~*(7-1-06)T

i. Instructional *~~technology~~* *techniques: Methodologies for training in a systematic and effective manner*; *~~(7-1-06)T~~*(7-1-06)T

ii. *Managing* behavior*s:* *~~technology~~* *Techniques and strategies for teaching adaptive behaviors*; *~~(7-1-06)T~~*(7-1-06)T

iii. Feeding; (7-1-06)T

iv. Communication*~~/sign language~~*; *~~(7-1-06)T~~*(7-1-06)T

v. Mobility; (7-1-06)T

~~vi. Assistance with medications (training in assistance with medications must be provided by a licensed nurse);~~ *~~(7-1-06)T~~*

vi*~~i~~*. Activities of daily living; (7-1-06)T

vii*~~i~~*. Body mechanics and lifting techniques; (7-1-06)T

~~ix~~viii. Housekeeping techniques; and (7-1-06)T

*i*x. Maintenance of a clean, safe, and healthy environment. (7-1-06)T

e. *The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed.* *(7-1-06)T*

~~e~~f. When residential habilitation services are provided in the provider's home, the

provider's home must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider's provider agreement. (7-1-06)T

02. Chore Services. Providers of chore services must meet the following minimum qualifications: (7-1-06)T

a. Be skilled in the type of service to be provided; and (7-1-06)T

b. Demonstrate the ability to provide services according to a plan of service. (7-1-06)T

03. Respite. Providers of respite care services must meet the following minimum qualifications: (7-1-06)T

a. Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (7-1-06)T

b. Have received care giving instructions in the needs of the person who will be provided the service; (7-1-06)T

c. Demonstrate the ability to provide services according to an plan of service; (7-1-06)T

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (7-1-06)T

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (7-1-06)T

f. Be free of communicable diseases. (7-1-06)T

04. Supported Employment. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. (7-1-06)T

05. Transportation. Providers of transportation services must: (7-1-06)T

a. Possess a valid driver's license; and (7-1-06)T

b. Possess valid vehicle insurance. (7-1-06)T

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations services must: (7-1-06)T

a. Be done under a permit, if required; and (7-1-06)T

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (7-1-06)T

07. Specialized Equipment and Supplies. Specialized Equipment and Supplies purchased under this service must: (7-1-06)T

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (7-1-06)T

b. Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the design of the equipment. (7-1-06)T

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (7-1-06)T

09. Home Delivered Meals. Services of Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (7-1-06)T

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; (7-1-06)T

b. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (7-1-06)T

c. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (7-1-06)T

d. Provide documentation of current driver's license for each driver; and (7-1-06)T

e. Must be inspected and licensed as a food establishment by the District Health Department. (7-1-06)T

10. Skilled Nursing. Nursing service providers must provide documentation of current Idaho licensure
as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. (7-1-06)T

11. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: (7-1-06)T

a. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (7-1-06)T

b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (7-1-06)T

c. Be a licensed pharmacist; or (7-1-06)T

d. Be a Qualified Mental Retardation Professional (QMRP). (7-1-06)T

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies." (7-1-06)T

12. Adult Day Care. Providers of adult day care services must be employed by or be affiliated with the residential habilitation agency that provides program coordination for the participant if the service is provided in a certified family home other than the participant's primary residence, be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: (7-1-06)T

a. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (7-1-06)T

b. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (7-1-06)T

c. Be free from communicable disease; (7-1-06)T

d. Satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"; (7-1-06)T

e. Demonstrate knowledge of infection control methods; and (7-1-06)T

f. Agree to practice confidentiality in handling situations that involve waiver participants. (7-1-06)T

13. Service Supervision. The plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. (7-1-06)T

706. DD/ISSH WAIVER SERVICES - ~~*PAYMENT METHODOLOGY*~~ *PROVIDER REIMBURSEMENT*.

01. Fee for Service. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (7-1-06)T

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (7-1-06)T

03. Rates. The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (7-1-06)T

707. -- 715. (RESERVED).

SUB AREA: SERVICE COORDINATION SERVICES
(Sections 720 Through 779)

720. SERVICE COORDINATION.
The Department will purchase service coordination for persons eligible for Enhanced Benefits who are unable, or have limited ability to gain access, coordinate or maintain services on their own or through other means. (7-1-06)T

721. SERVICE COORDINATION - DEFINITIONS.

01. Agency. An agency is a business entity that provides service coordination and includes at least a supervisor and a service coordinator. (7-1-06)T

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. (7-1-06)T

03. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (7-1-06)T

a. Hospitalization; (7-1-06)T

b. Loss of housing; (7-1-06)T

c. Loss of employment or major source of income; (7-1-06)T

d. Incarceration; or (7-1-06)T

e. Physical harm to self or others, including family altercation or psychiatric relapse. (7-1-06)T

04. Crisis Service Coordination. Crisis service coordination services are linking, coordinating and advocacy services provided to assist a participant to access emergency community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. (7-1-06)T

05. Current Assessment. An assessment that accurately reflects the status of the participant. (7-1-06)T

06. High Cost Services. As used in Subsection 725.01 of these rules, high cost

services are medical services that result in expensive claims payment or significant state general fund expenditure that may include: (7-1-06)T

a. Emergency room visits or procedures; (7-1-06)T

b. Inpatient medical and psychiatric services; (7-1-06)T

c. Nursing home admission and treatment; (7-1-06)T

d. Institutional care in jail or prison; (7-1-06)T

e. State, local, or county hospital treatment for acute or chronic illness; and(7-1-06)T

f. Outpatient hospital services. (7-1-06)T

07. Human Services Field. A particular area of academic study in health, social services, education, behavioral science or counseling. (7-1-06)T

08. Paraprofessional. An adult who has a minimum of a bachelor's degree in a human services field but no experience with participants, or a person without a degree but with a high school diploma or equivalency who has at least twelve (12) months' experience with the population to whom they will be providing services. (7-1-06)T

09. Practitioner of the Healing Arts. For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. (7-1-06)T

10. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. Service coordination is a brokerage model of case management. (7-1-06)T

11. Service Coordinator. An individual who provides service coordination to a Medicaid eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements in Section 729 of these rules. (7-1-06)T

12. Supports. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of his choice. (7-1-06)T

722. SERVICE COORDINATION SERVICES - ELIGIBILITY.
Participants identified in Sections 723 through 726 of these rules, who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, are eligible for service coordination. (7-1-06)T

723. SERVICE COORDINATION - ELIGIBILITY - INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.
Individuals with a developmental disability as defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules, are eligible for service coordination if they meet the following. (7-1-06)T

01. Age. Are adults eighteen (18) years of age or older, or adolescents fifteen to eighteen (15-18) years of age who are authorized to receive services through the Idaho State School and Hospital (ISSH) waiver; and (7-1-06)T

02. Diagnosis. Are diagnosed with a developmental disability, which means a chronic disability of a person which appears before the age of twenty-two (22) years of age and: (7-1-06)T

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and (7-1-06)T

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (7-1-06)T

c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated; and (7-1-06)T

03. Need Assistance. Require and choose assistance to adequately access services and supports necessary to maintain their independence in the community. (7-1-06)T

724. SERVICE COORDINATION - ELIGIBILITY - INDIVIDUALS WHO RECEIVE PERSONAL ASSISTANCE SERVICES.
Individuals who receive personal assistance services are eligible for service coordination if they: (7-1-06)T

01. Personal Care Services. Are adults or children who have been approved to receive state plan personal care services; or (7-1-06)T

02. Waiver Services. Are adults who have been approved to receive Aged and Disabled Home and Community Based Services Waiver; and (7-1-06)T

03. Need Assistance. Require and choose assistance to access services and supports necessary to maintain their independence in the community. (7-1-06)T

725. SERVICE COORDINATION - ELIGIBILITY - INDIVIDUALS WITH SEVERE AND PERSISTENT MENTAL ILLNESS.
Adults with severe and persistent mental illness are eligible for service coordination if they: (7-1-06)T

01. Adults Using High Cost Services. Are eighteen (18) years of age or older and using, or have a history of using, high cost medical services associated with periods of increased severity of mental illness; and (7-1-06)T

02. Diagnosis of Mental Illness. (7-1-06)T

a. Are diagnosed by a licensed physician or other licensed practitioner of the healing arts (licensed psychologist, licensed clinical social worker, licensed professional counselor, or licensed marriage or family therapist) with a condition of severe and persistent mental illness that is listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) within one (1) of the following classification codes: (7-1-06)T

i. Schizophrenia and other psychotic disorders; (7-1-06)T

ii. Delirium, dementia, and amnestic disorders; other cognitive disorders; and mental disorders due to a general medical condition; (7-1-06)T

iii. Mood disorders - bipolar and depressive; (7-1-06)T

iv. Schizoid, schizotypal, paranoid or borderline personality disorders; and (7-1-06)T

b. If the only diagnosis is mental retardation or is a substance related disorder, then the person is not included in the target population for mental health service coordination. (7-1-06)T

03. Need Assistance. Have mental illness of sufficient severity to cause a disturbance in their role performance or coping skills in at least two (2) of the following areas, on either a continuous (more than one (1) year) or an intermittent (at least once per year) basis: (7-1-06)T

a. 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. (7-1-06)T

b. 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 himself or manage his finances without assistance. (7-1-06)T

c. Social and 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. (7-1-06)T

d. 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. (7-1-06)T

e. 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. (7-1-06)T

f. Housing: Has lost or is at risk of losing his current residence. (7-1-06)T

g. Community: Exhibits inappropriate social behavior or otherwise causes a public

disturbance due to poor judgment, bizarre, or intrusive behavior, which may result in intervention by law enforcement, the judicial system, or both. (7-1-06)T

h. Health: Requires substantial assistance in maintaining physical health or in adhering to medically rigid prescribed treatment regimens. (7-1-06)T

726. SERVICE COORDINATION - ELIGIBILITY - CHILDREN UP TO THE AGE OF TWENTY-ONE.
To be eligible for service coordination under the Early and Periodic Screening Diagnosis and Treatment program (EPSDT), children must meet the following: (7-1-06)T

01. **Age**. Children from birth through the month in which their twenty first birthday occurs; and (7-1-06)T

02. **Diagnosis**. Must be identified by a physician or other practitioner of the healing arts in an EPSDT screen as having~~:~~ *one (1) of the diagnoses found in Subsections 726.03 through 726.05 of these rules.* ~~*(7-1-06)T*~~(7-1-06)T

~~*a*~~*03*. **Developmental Delay or Disability**~~:~~. A physical or mental condition which has a high probability of resulting in developmental delay or disability, or children who meet the definition of developmental disability as defined in Section 66-402, Idaho Code~~*; or*~~. ~~*(7-1-06)T*~~(7-1-06)T

~~*b*~~*04*. **Special Health Care Needs**~~:~~. Have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability~~*; or*~~. ~~*(7-1-06)T*~~(7-1-06)T

~~*c*~~*05*. ***Serious Emotional Disturbance (SED)***. ~~*Severe*~~ *Have a serious* emotional ~~*disorder: Have been diagnosed with a severe emotional disorder under DSM-IV- TR,*~~ *disturbance (SED)* with an expected duration of at least one (1) year~~;~~. ~~*and*~~ *The following definition of the SED target populations is based on the definition of SED found in the Children's Mental Health Services Act, Section 16-2403, Idaho Code.* ~~*(7-1-06)T*~~(7-1-06)T

a. *Presence of an emotional or behavioral disorder, according to the DSM-IV-TR or subsequent revisions to the DSM, which results in a serious disability; and* *(7-1-06)T*

b. *Requires sustained treatment interventions; and* *(7-1-06)T*

c. *Causes the child's functioning to be impaired in thought, perception, affect, or behavior.* *(7-1-06)T*

d. *The disorder is considered to be a serious disability if it causes substantial impairment in functioning. Functional impairment must be assessed using the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS). Substantial impairment requires a full eight (8) scale score of eighty (80) or higher on the CAFAS or a full seven (7) scale score of eighty (80) or higher on the PECFAS with "moderate" impairment in at least one (1) of the following three (3) scales:* *(7-1-06)T*

i. Self-Harmful Behavior; *(7-1-06)T*

ii. Moods/Emotions; or *(7-1-06)T*

iii. Thinking. *(7-1-06)T*

e. *A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance.* *(7-1-06)T*

0~~3~~6. **Need Assistance**. Have one (1) or more of the following problems associated with their diagnosis: (7-1-06)T

a. The condition has resulted in a level of functioning below normal age level in one (1) or more life areas such as school, family, or community; or (7-1-06)T

b. The child is at risk of placement in a more restrictive environment or the child is returning from an out of home placement as a result of the condition; or (7-1-06)T

c. There is danger to the health or safety of the child or the parent is unable to meet the needs of the child; or (7-1-06)T

d. Further complications may occur as a result of the condition without provision of service coordination services; or (7-1-06)T

e. The child requires multiple service providers and treatments. (7-1-06)T

727. SERVICE COORDINATION - COVERAGE AND LIMITATIONS.
Service coordination consists of the following functions: (7-1-06)T

01. Linking the Participant to Needed Services. "Linking" includes: (7-1-06)T

a. Finding, arranging and assisting the participant to maintain services, supports, and community resources identified on the service plan; and (7-1-06)T

b. Advocating for the unmet needs of the participant and to encourage independence. (7-1-06)T

02. Monitoring and Coordination of Services. Monitoring and coordinating services includes: (7-1-06)T

a. Assisting the participant and his family or guardian to coordinate and retain services, and assure consistency and non-duplication between services; and (7-1-06)T

b. Assuring that services are satisfactory to the participant and making adjustments in the plan of service when needed. (7-1-06)T

03. Assessment. Assessment for service coordination includes evaluation of the participant's ability to: gain access to needed services; coordinate or maintain those services; and identify the services and supports the participant needs to maintain his highest level of independence in the community. The assessment is an interactive process with maximum feasible involvement of the participant. (7-1-06)T

a. Assessment Content for Developmental Disability. A person with a developmental disability is assessed through the developmental disability eligibility criteria identified in Section 66-402, Idaho Code. The need for assistance, as defined in Sections 723 through 726 of these rules, must be determined through the person centered planning process as defined in IDAPA 16.04.11, "Developmental Disabilities Agencies," Section 011. (7-1-06)T

b. Assessment Content for Personal Assistance Services. A comprehensive evaluation of the participant's ability to function in the community including: (7-1-06)T

i. Medical needs, physical problems and strengths; (7-1-06)T

ii. Mental and emotional problems and strengths; (7-1-06)T

iii. Physical living environment; (7-1-06)T

iv. Vocational and educational needs; (7-1-06)T

v. Financial and social needs; (7-1-06)T

vi. Evaluation of the community support system including the involvement of family or significant others; (7-1-06)T

vi. Safety and risk factors; and (7-1-06)T

vii. Legal status. (7-1-06)T

c. Assessment Content for Mental Health. The assessment must focus on the following areas: (7-1-06)T

i. Mental status (psychiatric status for individuals with mental illness); (7-1-06)T

ii. Medical history and needs; (7-1-06)T

iii. Vocational status and needs; (7-1-06)T

iv. Financial status and needs; (7-1-06)T

v. Social relationships and supports; (7-1-06)T

vi. Family status and supports; (7-1-06)T

vii. Basic living skills and needs; (7-1-06)T

viii. Housing status and needs; and (7-1-06)T

ix. Community and legal status and needs. (7-1-06)T

d. EPSDT Assessment. The assessment for EPSDT Service Coordination services is completed by the Department. (7-1-06)T

04. Crisis Assistance. (7-1-06)T

a. Crisis Assistance. Crisis assistance, including services to prevent hospitalization or incarceration, may be provided before the completion of assessment and development of a plan of service. (7-1-06)T

b. Crisis Assistance for Children Receiving EPSDT Service Coordination. Additional crisis hours may be authorized for service coordination for children receiving EPSDT service coordination if at least four (4) hours of service coordination have already been provided in the month. (7-1-06)T

c. Crisis Assistance for Adults With a Developmental Disability. Crisis assistance for adults with a developmental disability may be authorized under community crisis supports as found in Section 507 through 515 of these rules. (7-1-06)T

d. Crisis Assistance for Adults With Severe and Persistent Mental Illness. Crisis assistance may be delivered prior to, or after, the completion of the assessment and individual service plan. Without authorization by the Department crisis assistance is limited to a total of three (3) hours per calendar month. The Department may authorize additional crisis case management services beyond the three (3) hour limit if a participant still has severe or prolonged crisis case management needs that meet all of the following criteria: (7-1-06)T

i. The service participant is at imminent risk within fourteen (14) days of hospitalization or institutionalization, including jail or nursing home; and (7-1-06)T

ii. The service participant is experiencing symptoms of psychiatric decompensation; and (7-1-06)T

iii. The service participant has already received the maximum number of monthly hours of ongoing case management and crisis case management services; and (7-1-06)T

iv. No other crisis assistance services are available to the participant under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR). (7-1-06)T

e. Crisis Assistance for Individuals Who Receive Personal Assistance Services. Additional hours for crisis assistance may be authorized for individuals who receive personal assistance services, if at least eight (8) hours of service coordination have already been provided in the month. (7-1-06)T

05. Limitations on the Provision of Direct Services. Providers of service coordination services may not provide both service coordination and direct service to the same Medicaid participant except for the following: (7-1-06)T

a. Early and Periodic Screening Diagnosis and Treatment (EPSDT). Providers of service coordination to children under the EPSDT option; or (7-1-06)T

b. Adults With Severe and Persistent Mental Illness. Providers of service coordination to adults with severe and persistent mental illness. (7-1-06)T

06. Limitations on Service Coordination. When an assessment indicates the need for medical, psychiatric, social, educational, or other services, referral or arrangement for such services may be included as service coordination services. Service coordination is limited to the following: (7-1-06)T

a. Service Coordination for Persons With Mental Illness. Five (5) hours per month for participants with mental illness. (7-1-06)T

b. Service Coordination for Personal Assistance Services. Up to eight (8) hours per month for participants who have been approved to receive personal assistance services, as prior authorized by the Department. (7-1-06)T

c. Other Populations. Service coordination services to participants with developmental disabilities and children under the EPSDT option are prior authorized by the Department on a monthly basis. (7-1-06)T

d. Assessment and Plan Development. Assessment and plan development are reimbursable except for the initial plan development for EPSDT service coordination. (7-1-06)T

e. Initial Plan Development. Reimbursement for the initial evaluation and individual service plan development will be paid based on an hourly rate, not to exceed six (6) hours. (7-1-06)T

728. SERVICE COORDINATION - PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. All service coordination services must be prior authorized by the Department, except the following adult mental health service coordination services: initial assessment for services; five (5) hours of ongoing service coordination per month; and the first three (3) hours of crisis service coordination per month. For adults with mental illness, crisis service coordination over three (3) hours per month must be prior authorized. (7-1-06)T

02. Service Plan Development. A written service coordination plan must be developed and implemented within sixty (60) days after the participant chooses a service coordination agency except in the case of adults with severe and persistent mental illness; in which case the time limit is thirty (30) days. The plan must be updated at least annually. The plan must address the service coordination needs of the participant as identified in the assessment. (7-1-06)T

a. Service Plan Content for Individuals With Developmental Disabilities. The service coordination plan for individuals with developmental disabilities is incorporated into the participant's plan of service. The content is identified in Section 512 of these rules. (7-1-06)T

b. Service Plan Content for Individuals Receiving Personal Assistance Services. The individual's service plan must contain at least the following: (7-1-06)T

i. Problems identified during the assessment; (7-1-06)T

ii. Overall goals to be achieved; (7-1-06)T

iii. Reference to all services and contributions provided by the informal support system including the actions, if any, taken by the service coordinator to develop the support system; (7-1-06)T

iv. Documentation of who has been involved in the service planning, including the participant's involvement; (7-1-06)T

v. Schedules for service coordination monitoring and reassessment; (7-1-06)T

vi. Documentation of unmet needs and service gaps; and (7-1-06)T

vii. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery. (7-1-06)T

c. Service Plan Content for Individuals With Severe And Persistent Mental Illness. The service coordination plan must include the following: (7-1-06)T

i. A list of problems and needs identified during the assessment; (7-1-06)T

ii. Concrete measurable goals and objectives to be achieved by the service coordinator; (7-1-06)T

iii. Time frames for achievement of the goals and objectives; (7-1-06)T

iv. Reference to any formal services arranged including specific providers; (7-1-06)T

v. Frequency of services initiated; and (7-1-06)T

vi. Documentation of who was involved in the service planning. (7-1-06)T

d. Service Plan Development for EPSDT Service Coordination. The initial plan for EPSDT service coordination is completed by the Department or designee. An EPSDT service coordination agency selected by the family develops an annual service coordination plan and submits it to the Department for prior authorization of continued service coordination. (7-1-06)T

03. Documentation of Service Coordination. Agencies must maintain records that

contain documentation describing the services provided, review of the continued need for service coordination and progress toward each service coordination goal. Documentation must be completed as required in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include all of the following: (7-1-06)T

a. Name. The name of the eligible participant. (7-1-06)T

b. Provider. The name of the provider agency and the person providing the direct services. (7-1-06)T

c. Time and Place of Service. The date, time and place the service was provided. (7-1-06)T

d. Documentation of Eligibility. A copy of the current assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed service plan. (7-1-06)T

e. Description. Agency records must contain documentation describing details of the service provided signed by the person who delivered the service. (7-1-06)T

f. Progress Review. Review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. (7-1-06)T

g. Satisfaction With Service. Documentation of the participant's, family's, or guardian's satisfaction with service. (7-1-06)T

h. Informed Consent. A copy of the informed consent form signed by the participant or guardian which documents that the participant has been informed of his rights to refuse service coordination and to choose his providers. (7-1-06)T

i. Service Plan. A service plan that is signed by the participant or his legal representative, and the plan developer. Mental health service coordination plans must also be signed by a physician or other practitioner of the healing arts. The service coordinator must also document that a copy of the plan was given to the participant or his legal representative. The plan must be updated and authorized when required, but at least annually. (7-1-06)T

j. Crisis Assistance Documentation for Adults With Severe and Persistent Mental Illness. Documentation to support authorization of crisis assistance beyond the monthly limitation must be submitted to the Department before such authorization may be granted. Documentation to support delivery of crisis assistance must also be maintained in the participant's agency record and must include: (7-1-06)T

i. A description of the crisis, including identification of unanticipated events that precipitate the need for crisis case management services; (7-1-06)T

ii. A brief review of case management and other services or supports available to, or already provided to, the participant to resolve the crisis; (7-1-06)T

iii. A crisis resolution plan; and (7-1-06)T

iv. Outcomes of crisis assistance service provision. (7-1-06)T

04. Participant Choice Of Service Coordination Providers. Eligible participants have the option to select service coordinators. A participant must have free choice of a service coordination provider. (7-1-06)T

05. Service Coordinator Contact And Availability. At least every thirty (30) days, service coordinators must have contact with the participant, legal guardian or provider who can verify the participant's well being and whether services are being provided according to the written plan. The frequency, mode of contact, and person being contacted must be identified in the plan. (7-1-06)T

a. The mode and frequency of contact for developmental disability service coordination must be identified in the plan and must meet the needs of the participant. Service coordinators must have face-to-face contact with each participant at least every ninety (90) days. (7-1-06)T

b. The mode and frequency of contact for mental health service coordination must be identified in the plan and must meet the needs of the participant. Mental health service coordinators must have face-to-face contact every month with each participant. (7-1-06)T

c. The mode and frequency of contact for Early and Periodic Screening and Diagnosis and Treatment (EPSDT) service coordination must be identified in the plan and must meet the needs of the child. EPSDT service coordinators must have face to face contact with the child and the child's family at least every ninety (90) days. (7-1-06)T

d. The mode and frequency of contact for Personal Care Service (PCS) service coordination must be identified in the plan and must meet the needs of the participant. PCS service coordinators must have face to face contact with the participant and others at least every ninety (90) days as necessary to coordinate and monitor the progress of the existing individual service plan. (7-1-06)T

e. Hours of Availability. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include on the plan what the participant, families, and providers should do in an emergency situation. (7-1-06)T

729. SERVICE COORDINATION - PROVIDER QUALIFICATIONS.
Services will be provided by an organized provider agency that has entered into a provider agreement with the Department. (7-1-06)T

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. (3-20-04)

02. Work Experience And Supervision. All service coordinators must have at least twelve (12) months' experience working with the population they will be serving or be supervised

by a qualified service coordinator. (7-1-06)T

03. Minimum Education Requirements. All service coordinators must have a minimum of a bachelor's degree in a human services field from a nationally accredited university or college; or be a licensed professional nurse, also referred to as a registered nurse (RN). (7-1-06)T

04. Mandatory Criminal History Check Requirements. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." (7-1-06)T

05. Health, Safety And Fraud Reporting. Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to the Department. Service coordinators must also report fraud, including billing of services that were not provided, to the Department unit responsible for authorizing the service; and to the Surveillance and Utilization Review Unit (SUR) within the Department or its toll-free Medicaid fraud hotline. (7-1-06)T

730. SERVICE COORDINATION - PARAPROFESSIONALS.
Under the supervision of a qualified service coordinator, paraprofessionals may be used to assist in the implementation of a service coordination plan except for plans of participants with a mental illness. Paraprofessionals must be able to read and write at a level equal with the paperwork and forms involved in the provision of service. (7-1-06)T

731. SERVICE COORDINATION - SUPERVISION OF SERVICE COORDINATION.
Service coordination agencies must provide supervision to qualified service coordinators and paraprofessionals employed by the agency. Agency supervisors must have the following qualifications: (7-1-06)T

01. Master's Degree. Master's degree in a human services field and one (1) year's experience with the population for whom they will be supervising services. For supervisors of service coordination for participants with mental illness, this experience must be in a mental health service setting; or (7-1-06)T

02. Bachelor's Degree. Bachelor's degree in a human services field or RN degree and two (2) years' experience with the population for whom they will be supervising services. For supervisors of service coordination to participants with mental illness, this experience must be in a mental health service setting. (7-1-06)T

732. SERVICE COORDINATION - INDIVIDUAL SERVICE COORDINATOR CASE LOADS.
The total caseload of a service coordinator must assure quality service delivery and participant satisfaction. (7-1-06)T

733. -- 735. (RESERVED).

736. SERVICE COORDINATION - ~~*PAYMENT METHODOLOGY*~~ *PROVIDER REIMBURSEMENT*.

01. Limitations on Payment for Service Coordination. (7-1-06)T

a. Duplication. Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. (7-1-06)T

b. Payment for Service Coordination. Subject to the service limitations in Subsection 736.01.F of this rule, only the following services are reimbursable: (7-1-06)T

i. Face to face contact as required in Subsection 728.05 of these rules. (7-1-06)T

ii. Telephone contact between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal representative, or other interested persons; or (7-1-06)T

iii. Face to face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. (7-1-06)T

iv. Paperwork that is associated with obtaining certain needed services such as food stamps, energy assistance, emergency housing, or legal services. (7-1-06)T

c. Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge. Service coordination may be provided during the last thirty (30) days of an inpatient stay, or if the stay is not expected to last longer than thirty (30) days, when the service does not duplicate the discharge responsibilities of the facility. (7-1-06)T

d. Incarceration. Service coordination is not reimbursable when the participant is incarcerated. (7-1-06)T

e. Services Delivered Prior to Assessment. Payment for on-going service coordination will not be made prior to the completion of the assessment and service plan. (7-1-06)T

f. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. For service coordination paid at an hourly rate, providers will not be reimbursed for more than one (1) contact during a single fifteen (15) minute time period. (7-1-06)T

02. Healthy Connections. If the participant is enrolled in Healthy Connections, the

referral for assessment and provision of services must be authorized by a physician or other practitioner of the healing arts, except for participants who receive personal care services or aged and disabled waiver services. (7-1-06)T

03. Group Service Coordination. Payment is not allowed for service coordination provided to a group of participants. (7-1-06)T

737. -- 779. (RESERVED).

SUB AREA: BREAST AND CERVICAL CANCER PROGRAM
(Sections 780 Through 799)

780. BREAST OR CERVICAL CANCER PROGRAM THROUGH THE WOMEN'S HEALTH CHECK.
Women who are determined eligible for Medicaid through the Women's Health Check program are eligible for enhanced Medicaid benefits until it is determined that cancer treatment has ended. (7-1-06)T

781. BREAST OR CERVICAL CANCER PROGRAM - DEFINITIONS.

01. Primary Treatment. The initial action of treating a patient medically or surgically for cancer using conventional treatment modalities. (7-1-06)T

02. Adjuvant Therapy. Treatment that includes either radiation or systemic chemotherapy, or both, as part of the plan of care. (7-1-06)T

03. End of Treatment. Cancer treatment ends: (7-1-06)T

a. When the woman's plan of care reflects a status of surveillance, follow-up, or maintenance mode; or (7-1-06)T

b. If the woman's treatment relies on an unproven procedure, as referred to in IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Section 390 in lieu of primary or adjuvant treatment. (7-1-06)T

782. BREAST OR CERVICAL CANCER PROGRAM - ELIGIBILITY.
Women eligible for Medical Assistance, as provided for in IDAPA 16.03.05, “Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD),” Section 802, will be covered while receiving either primary or adjuvant cancer treatment, or both. (7-1-06)T

783. BREAST OR CERVICAL CANCER PROGRAM - PROCEDURAL REQUIREMENTS.
The Division of Medicaid, or its successor, is responsible for determining when a woman's treatment has ended. (7-1-06)T

784. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0603

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is October 1, 2006. This pending rule has been adopted by the agency and is now pending review by the 2007 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 56-250 through 56-257, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and amending the 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 text is being amended to have the Aged and Disabled Waiver Services provider qualifications for residential rehabilitation services aligned with the provider qualifications under the Developmental Disabilities and Idaho State School and Hospital (DD/ISSH) Waiver Services. The rules have also had references updated.

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 from the proposed text are printed in this bulletin.

The original text of the proposed rule was published in the November 1, 2006, Idaho Administrative Bulletin, Vol. 06-11, pages 51 through 74.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Chris Baylis at (208) 364-1891.

DATED this 30th day of November, 2006.

DEPARTMENT OF HEALTH & WELFARE **Docket No. 16-0310-0603**
Medicaid Enhanced Plan Benefits **PENDING RULE**

THIS NOTICE WAS PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: **The effective dates of the temporary rules are October 1, 2006.**

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 Sections 56-202(b), and 56-250 through 56-257, Idaho Code.

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

Wednesday, November 8, 2006
2:00 p.m.
DHW - Region IV Office
1720 Westgate Dr.
Suite D, Room 119
Boise, 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 nontechnical explanation of the substance and purpose of the proposed rulemaking:

The current Traumatic Brain Injury (TBI) Waiver expires on September 30, 2006. In order to not disrupt services for the TBI Waiver participants, the Department is moving the coverage for TBI participants under the rules for Aged and Disabled (A&D) Waiver services. The A&D Waiver has similar eligibility criteria for the level of care and services that are currently provided to TBI Waiver participants.

The sections of rules outlining the TBI Waiver Services are being deleted. Services that were covered in the TBI Waiver services for habilitation, supported employment, behavior consultation, and crisis management will be provided under the Aged and Disabled Waiver Services rules. These changes will assure continuity of care for those participants who have been served under the former TBI Waiver. Minor changes have also been made to the rules for consistency and clarification.

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:

These rule amendments confer a benefit to eligible Medicaid participants in Idaho.

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

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule changes confer a benefit.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, November 22, 2006.

DATED this 28th day of September, 2006.

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

THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE

075. ENHANCED PLAN BENEFITS - COVERED SERVICES.
Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (7-1-06)T

01. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (7-1-06)T

02. Enhanced Mental Health Benefits. Enhanced Mental Health services are provided under Sections 100 through 147 of these rules. (7-1-06)T

03. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (7-1-06)T

04. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (7-1-06)T

05. Long Term Care Services. The following services are provided under the Long Term Care Services. (7-1-06)T

a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (7-1-06)T

b. Personal Care Services as described in Sections 300 through ~~319~~ 308 of these rules. ~~(7-1-06)T~~(10-1-06)T

c. A & D Wavier Services as described in Sections 320 through ~~335~~ 330 of these rules. ~~(7-1-06)T~~(10-1-06)T

~~**d.** TBI Waiver Services as described in Sections 335 through 350 of these rules. (7-1-06)T~~

06. Hospice. Hospice services as described in Sections 450 through 459 of these rules. (7-1-06)T

07. Developmental Disabilities Services. (7-1-06)T

a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (7-1-06)T

b. Behavioral Health Prior Authorization as described in Sections 507 through 520 of these rules. (7-1-06)T

c. ICF/MR as described in Sections 580 through 649 of these rules. (7-1-06)T

d. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules. (7-1-06)T

08. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (7-1-06)T

09. Breast and Cervical Cancer Program. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (7-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Adult Day Care. Adult day care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (7-1-06)T

02. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22,

"Residential Care or Assisted Living Facilities in Idaho," that includes: (7-1-06)T

a. Medication management; (7-1-06)T

b. Assistance with activities of daily living; (7-1-06)T

c. Meals, including special diets; (7-1-06)T

d. Housekeeping; (7-1-06)T

e. Laundry; (7-1-06)T

f. Transportation; (7-1-06)T

g. Opportunities for socialization; (7-1-06)T

h. Recreation; and (7-1-06)T

i. Assistance with personal finances. (7-1-06)T

j. Administrative oversight must be provided for all services provided or available in this setting. (7-1-06)T

k. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (7-1-06)T

03. Assistive Technology. Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. (7-1-06)T

04. Assisted Transportation. Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (7-1-06)T

a. Assisted transportation service is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 860 through 876, and will not replace it. (7-1-06)T

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (7-1-06)T

05. Attendant Care. Attendant care services are those services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services

may include~~, but are not limited to~~ personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Services may occur in the participant's home, community, work, school or recreational settings.
~~(7-1-06)T~~(10-1-06)T

a. To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized. (7-1-06)T

b. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (7-1-06)T

06. Chore Services. Chore services include the services provided in Subsection 326.06.a. and 326.06.b. of this rule: (7-1-06)T

a. Intermittent Assistance may include the following. (7-1-06)T

i. Yard maintenance; (7-1-06)T

ii. Minor home repair; (7-1-06)T

iii. Heavy housework; (7-1-06)T

iv. Sidewalk maintenance; and (7-1-06)T

v. Trash removal to assist the participant to remain in their home. (7-1-06)T

b. Chore activities may include the following: (7-1-06)T

i. Washing windows; (7-1-06)T

ii. Moving heavy furniture; (7-1-06)T

iii. Shoveling snow to provide safe access inside and outside the home; (7-1-06)T

iv. Chopping wood when wood is the participant's primary source of heat; and (7-1-06)T

v. Tacking down loose rugs and flooring. (7-1-06)T

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payer is willing to or is responsible for their provision. (7-1-06)T

d. In the case of rental property, the responsibility of the landlord, pursuant to the

lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (7-1-06)T

07. Adult Companion. In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (7-1-06)T

08. Consultation. Consultation services are services to a participant or family member. Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (7-1-06)T

09. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: (7-1-06)T

a. Rent or own their own home; (7-1-06)T

b. Are alone for significant parts of the day; (7-1-06)T

c. Have no regular caretaker for extended periods of time; and (7-1-06)T

d. Are unable to prepare a balanced meal. (7-1-06)T

10. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (7-1-06)T

11. Home Modifications. Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization. Such adaptations may include: (7-1-06)T

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (7-1-06)T

b. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (7-1-06)T

c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (7-1-06)T

12. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who: (7-1-06)T

a. Rent or own their home, or live with unpaid relatives; (7-1-06)T

b. Are alone for significant parts of the day; (7-1-06)T

c. Have no caretaker for extended periods of time; and (7-1-06)T

d. Would otherwise require extensive routine supervision. (7-1-06)T

13. Psychiatric Consultation. Psychiatric Consultation is direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (7-1-06)T

14. Respite Care. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (7-1-06)T

15. Service Coordination. Service coordination includes all of the activities contained in Section 727 of these rules. Such services are designed to foster independence of the participant, and will be time limited. (7-1-06)T

a. All services will be provided in accordance with an individual service plan. All services will be incorporated into the Individual Service plan and authorized by the RMS. (7-1-06)T

b. The service coordinator must notify the RMS, the Personal Assistance Agency, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition. (7-1-06)T

16. Skilled Nursing Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit.Nursing services may include but are not limited to: (7-1-06)T

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (7-1-06)T

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (7-1-06)T

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (7-1-06)T

d. Injections; (7-1-06)T

e. Blood glucose monitoring; and (7-1-06)T

f. Blood pressure monitoring. (7-1-06)T

17. **Habilitation**. Habilitation services consist of an integrated array of individually-tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in alternate family homes. (10-1-06)T

a. Residential habilitation services assist the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (10-1-06)T

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (10-1-06)T

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (10-1-06)T

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; (10-1-06)T

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (10-1-06)T

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

(10-1-06)T

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (10-1-06)T

b. Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (10-1-06)T

18. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (10-1-06)T

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained by RMS in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. (10-1-06)T

b. Federal Financial Participation (FFP) can not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment programs, payments that are passed through to beneficiaries of supported employment programs, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (10-1-06)T

19. Behavior Consultation or Crisis Management. Behavior consultation or crisis management consists of services that provide direct consultation and clinical evaluation of participants who are currently experiencing, or are expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also include emergency back-up that provides direct support and services to a participant in crisis. (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED OR DISABLED WAIVER SERVICES - PROCEDURAL REQUIREMENTS.

01. Role of the Regional Medicaid Services. The RMS will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by RMS staff or a contractor. The RMS will review and approve all individual service plans, and ~~the~~ will authorize Medicaid payment by type, scope, and amount. ~~(7-1-06)T~~(7-1-06)T

a. Services which are not in the individual service plan approved by the RMS are not eligible for Medicaid payment. (7-1-06)T

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (7-1-06)T

c. The earliest date that services may be approved by the RMS for Medicaid payment is the date that the participant's individual service plan is signed by the participant or his designee. (7-1-06)T

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (7-1-06)T

a. The UAI; (7-1-06)T

b. The individual service plan developed by the Department or its contractor; and (7-1-06)T

c. Any other medical information which verifies the need for nursing facility services in the absence of the waiver services. (7-1-06)T

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the RMS or its contractor. (7-1-06)T

04. ~~Service Delivered Following a Written~~ Individual Service Plan. All waiver services must be authorized by the RMS in the Region where the participant will be residing and services provided based on a written individual service plan. ~~(7-1-06)T~~(10-1-06)T

a. The initial individual service plan is developed by the RMS or its contractor, based on the UAI, in conjunction with: (7-1-06)T

i. The waiver participant (with efforts made by the RMS to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); ~~and~~ ~~(7-1-06)T~~(10-1-06)T

ii. The guardian, when appropriate; ~~and~~ ~~(7-1-06)T~~(10-1-06)T

iii. The supervising nurse or case manager, when appropriate; and (7-1-06)T

iv. Others identified by the waiver participant. (7-1-06)T

b. The individual service plan must include the following: (7-1-06)T

i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; ~~*and*~~ ~~*(7-1-06)T*~~(10-1-06)T

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; ~~*and*~~ ~~*(7-1-06)T*~~(10-1-06)T

iii. The providers of waiver services when known; ~~*and*~~ ~~*(7-1-06)T*~~(10-1-06)T

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (7-1-06)T

v. The signature of the participant or his legal representative, agreeing to the plan. (7-1-06)T

c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (7-1-06)T

d. All services reimbursed under the Aged or Disabled Waiver must be authorized by the RMS prior to the payment of services. (7-1-06)T

e. The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the RMS or its contractor. (7-1-06)T

05. Service Delivered Following a Written Plan of Care. All services that are provided must be based on a written plan of care. (10-1-06)T

a. The plan of care is developed by the plan of care team which includes: (10-1-06)T

i. The waiver participant with efforts made to maximize his participation on the team by providing him with information and education regarding his rights; (10-1-06)T

ii. The Department's administrative case manager; (10-1-06)T

iii. The guardian when appropriate; (10-1-06)T

iv. Service provider identified by the participant or guardian; and (10-1-06)T

v. May include others identified by the waiver participant. (10-1-06)T

b. The plan of care must be based on an assessment process approved by the Department. (10-1-06)T

c. The plan of care must include the following: (10-1-06)T

i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; (10-1-06)T

ii. Supports and service needs that are to be met by the participant's family, friends and other community services; (10-1-06)T

iii. The providers of waiver services; (10-1-06)T

iv. Goals to be addressed within the plan year; (10-1-06)T

v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and (10-1-06)T

vi. The signature of the participant or his legal representative. (10-1-06)T

d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (10-1-06)T

e. The Department's case manager monitors the plan of care and all waiver services. (10-1-06)T

f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department. (10-1-06)T

0~~5~~6. Provider Records. Records will be maintained on each waiver participant. (7-1-06)T

a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-06)T

i. Date and time of visit; (7-1-06)T

ii. Services provided during the visit; (7-1-06)T

iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (7-1-06)T

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the RMS or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (7-1-06)T

b. The provider is required to keep the original service delivery record. A copy of the

service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the RMS. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (7-1-06)T

c. The individual service plan initiated by the RMS or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the RMS to each individual service provider with a release of information signed by the participant or legal representative. (7-1-06)T

0~~6~~7. Provider Responsibility for Notification. The service provider is responsible to notify the RMS, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (7-1-06)T

0~~7~~8. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (7-1-06)T

0~~8~~9. Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date which services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. (7-1-06)T

329. AGED OR DISABLED WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.

Each provider must have a signed provider agreement with the Department for each of the services it provides. (7-1-06)T

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations ~~*where*~~ in which no agency exists, or no fiscal intermediary is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by an agency or fiscal intermediary is still not available. ~~*(7-1-06)T*~~(10-1-06)T

02. Personal Assistance Agency That Provides Fiscal Intermediary Services. A personal assistance agency that focuses on fostering participant independence and personal control of services delivered. The core tasks are: (7-1-06)T

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (7-1-06)T

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (7-1-06)T

c. To bill the Medicaid program for services approved and authorized by the

Department; (7-1-06)T

d. To collect any participant participation due; (7-1-06)T

e. To pay personal assistants and other waiver service providers for service; (7-1-06)T

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (7-1-06)T

g. To offer a full range of services and perform all services contained in a written agreement between the participant and the provider; (7-1-06)T

h. Make referrals for PCS eligible participant for service coordination when a need for such services is identified; and (7-1-06)T

i. Obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (7-1-06)T

03. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. (7-1-06)T

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (7-1-06)T

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (7-1-06)T

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (7-1-06)T

05. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (7-1-06)T

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (7-1-06)T

a. A master's degree in a behavioral science; (7-1-06)T

b. Be licensed in accordance with state law and regulations; or (7-1-06)T

c. Have a bachelor's degree and work for an agency with direct supervision from a

licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (7-1-06)T

07. Service Coordination. Service coordinators and service coordination agencies must meet the requirements specified in Section 729 of these rules unless specifically modified by another section of these rules. (7-1-06)T

08. Consultation Services. Services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (7-1-06)T

09. Adult Residential Care Providers. Adult Residential Care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are is provided to meet the needs of the participants accepted for admission. (7-1-06)T

10. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (7-1-06)T

a. Supervising the direct service; (7-1-06)T

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (7-1-06)T

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (7-1-06)T

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (7-1-06)T

e. Being inspected and licensed as a food establishment by the district health department. (7-1-06)T

11. Personal Emergency Response Systems. Providers must demonstrate that the devices installed in waiver participant's homes meet Federal Communications Standards, Underwriter's Laboratory Standards, or equivalent standards. (7-1-06)T

12. Adult Day Care. Facilities ~~*which*~~ that provide adult day care must be maintained in safe and sanitary manner. ~~*(7-1-06)T*~~(10-1-06)T

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (7-1-06)T

b. Providers ~~*accepting*~~ who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. ~~*(7-1-06)T*~~(10-1-06)T

13. Assistive Technology. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (7-1-06)T

14. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications. (7-1-06)T

15. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. (7-1-06)T

16. Homemaker Services. The homemaker must be an employee of record or fact of an agency. (7-1-06)T

17. Home Modifications. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (7-1-06)T

18. Residential Habilitation Provider Qualifications. *Residential habilitation services must be provided by an agency that is capable of supervising the direct services provided. Individuals who provide residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a residential habilitation agency. The residential habilitation agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a residential habilitation agency.* Providers of residential habilitation services must meet the following requirements: ~~*(10-1-06)T*~~(10-1-06)T

a. Direct service staff must meet the following minimum qualifications: (10-1-06)T

i. Be at least eighteen (18) years of age; (10-1-06)T

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of care; (10-1-06)T

iii. Have current CPR and First Aid certifications; (10-1-06)T

iv. Be free from communicable diseases; (10-1-06)T

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (10-1-06)T

vi. Satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks;" (10-1-06)T

~~*vi. 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* (10-1-06)T~~

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (10-1-06)T

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.18.c. of this rule. ~~*Additional training requirements may also include:* (10-1-06)T~~(10-1-06)T

~~*i. Instructional technology;* (10-1-06)T~~

~~*ii. Behavior technology;* (10-1-06)T~~

~~*iii. Feeding;* (10-1-06)T~~

~~*iv. Communication or sign language;* (10-1-06)T~~

~~*v. Mobility;* (10-1-06)T~~

~~*vi. Assistance with medications, training in assistance with medications must be provided by a licensed nurse;* (10-1-06)T~~

~~*vii. Activities of daily living;* (10-1-06)T~~

~~*viii. Body mechanics and lifting techniques;* (10-1-06)T~~

~~*ix. Housekeeping techniques and maintenance of a clean, safe, and healthy environment.* (10-1-06)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 service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (10-1-06)T

d. *Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects:* *(10-1-06)T*

i. Purpose and philosophy of services; *(7-1-06)T*

ii. Service rules; *(7-1-06)T*

iii. Policies and procedures; *(7-1-06)T*

iv. Proper conduct in relating to waiver participants; (7-1-06)T

v. Handling of confidential and emergency situations that involve the waiver participant; (7-1-06)T

vi. Participant rights; (7-1-06)T

vii. Methods of supervising participants; (7-1-06)T

viii. Working with individuals with traumatic brain injuries; and (7-1-06)T

ix. Training specific to the needs of the participant. (7-1-06)T

e. *Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: (10-1-06)T*

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (10-1-06)T

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (10-1-06)T

iii. Feeding; (10-1-06)T

iv. Communication; (10-1-06)T

v. Mobility; (10-1-06)T

vi. Activities of daily living; (10-1-06)T

vii. Body mechanics and lifting techniques; (10-1-06)T

viii. Housekeeping techniques; and (10-1-06)T

ix. Maintenance of a clean, safe, and healthy environment. (10-1-06)T

f. *The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed; and (10-1-06)T*

~~d~~g. When residential habilitation services are provided in the provider's home, the provider must ~~*be certified by the Department as a certified family home and*~~ meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider agreement or contract. ~~*(10-1-06)T*~~(10-1-06)T

19. **Day Rehabilitation Provider Qualifications**. Providers of day rehabilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. (10-1-06)T

20. **Supported Employment Service Providers**. Supported employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury training course approved by the Department. (10-1-06)T

21. **Behavior Consultation or Crisis Management Service Providers**. Behavior consultation or crisis management providers must meet the following: (10-1-06)T

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (10-1-06)T

b. Be a licensed pharmacist; or (10-1-06)T

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 (10-1-06)T

d. Take a traumatic brain injury training course approved by the Department. (10-1-06)T

e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (10-1-06)T

(BREAK IN CONTINUITY OF SECTIONS)

~~***335. TRAUMATIC BRAIN INJURY (TBI) WAIVER SERVICES.***~~
~~*Pursuant to 42 CFR Section 435.217, it is the intention of the Department to provide waiver services to eligible 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 participant to be eligible, the Department must find that the 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 nursing facility under Sections 222 and 226 of these rules.*~~ ~~*(7-1-06)T*~~

~~336. (RESERVED).~~

~~337. TBI WAIVER SERVICES - ELIGIBILITY.~~
~~Persons who are Medicaid eligible, whose injury to the brain occurred on or after the age of twenty-two (22) and have been diagnosed with a traumatically acquired non-degenerative, structural brain injury resulting in residual deficits and disability who require the level of care provided in a nursing facility. (7-1-06)T~~

~~01. 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 in the table below:~~

~~TABLE 337~~	
~~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~~

~~(7-1-06)T~~

~~338. TBI WAIVER SERVICES - ELIGIBILITY DETERMINATION.~~
~~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 medical assistance eligibility requirements as described in IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind, and Disabled (AABD)," Section 787. In addition, waiver participants must meet the following requirements: (7-1-06)T~~

~~01. Requirements for Determining Participant Eligibility. The Regional Medicaid Services must determine that: (7-1-06)T~~

~~a. The participant would qualify for nursing facility level of care as set forth in Sections 222 and 226 of these rules if the waiver services listed in Section 340 of these rules were~~

~~not made available;~~ ~~(7-1-06)T~~

~~**b.** The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by the Department's Case Manager, with input from the 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; and~~ ~~(7-1-06)T~~

~~**c.** The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of nursing facility care and other medical costs. Individual 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 nursing facility 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.~~ ~~(7-1-06)T~~

~~**d.** Following the approval by the Regional Medicaid Services for services under the waiver, the participants must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program.~~ ~~(7-1-06)T~~

~~**02. Admission to a Nursing Facility**. A participant who is determined by the Regional Medicaid 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 a nursing facility.~~ ~~(7-1-06)T~~

~~**03. Self Reliance Specialist**. The 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 nursing facility except that the self reliance specialist will forward potentially eligible applications immediately to the Regional Medicaid Services for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process.~~ ~~(7-1-06)T~~

~~**04. Redetermination Process. Case Redetermination**.~~ ~~(7-1-06)T~~

~~**a.** Financial redetermination will be conducted pursuant to 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 Services, or sooner at the request of the 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.~~ ~~(7-1-06)T~~

~~**b.** The redetermination process will assess the following factors:~~ ~~(7-1-06)T~~

~~i. The participant's continued need for waiver services; and~~ ~~(7-1-06)T~~

~~ii. Discharge from the waiver services program. (7-1-06)T~~

~~**339. HOME AND COMMUNITY-BASED WAIVER PARTICIPANT LIMITATIONS.** The number of Medicaid participants to receive waiver services under the home and community based waiver for 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 30th of each new waiver year. The earliest effective date of waiver service delivery for these participants will be October 1st of each new waiver year. (7-1-06)T~~

~~**340. TBI WAIVER SERVICES – COVERAGE AND LIMITATIONS.** Services that may be provided under the waiver consist of residential habilitation, chore, respite care, supported employment, transportation, environmental accessibility adaptations, specialized medical equipment and supplies, personal emergency response system, day rehabilitation, home delivered meals, behavior consultation/crisis management, and skilled nursing services. Also included are extended state plan services including administrative case management, physical therapy, occupational therapy, speech therapy, personal care services. (7-1-06)T~~

~~**01. Residential Habilitation**. Services consist of an integrated array of individually-tailored services and supports furnished to eligible 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 Subsections 340.02 and 340.03 of these rules. (7-1-06)T~~

~~**02. 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: (7-1-06)T~~

~~**a.** 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; (7-1-06)T~~

~~**b.** Money Management. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (7-1-06)T~~

~~**c.** 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; (7-1-06)T~~

~~**d.** Socialization. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going~~

~~basis. Socialization training does not include participation in nontherapeutic activities which are merely diversional or recreational in nature;~~ ~~(7-1-06)T~~

~~**e.** 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; or~~ ~~(7-1-06)T~~

~~**f.** 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.~~ ~~(7-1-06)T~~

~~**03. Personal Assistance Services**. Services consist of assisting the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf.~~ ~~(7-1-06)T~~

~~**04. Personal Assistance Services Skills Training**. Skills training consists of teaching waiver participants, family members, alternative family caregiver, or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skill training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs.~~ ~~(7-1-06)T~~

~~**05. 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 participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant.~~ ~~(7-1-06)T~~

~~**06. Respite Care Services**. Services consist of those services provided, on a short term basis, in the home of either the waiver 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 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 participants who reside with non-paid caregivers.~~ ~~(7-1-06)T~~

~~**07. Supported Employment**. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been~~

~~*interrupted or intermittent as a result of a severe disability; 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.* (7-1-06)T~~

~~***08. Exclusions From Supported Employment***. (7-1-06)T~~

~~***a.*** *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. (7-1-06)T~~

~~***b.*** *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 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.* (7-1-06)T~~

~~***09. Transportation Services***. *Services consist of services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the 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 will 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.* (7-1-06)T~~

~~***10. Environmental Accessibility Adaptations***. *Adaptations consist of interior or exterior physical adaptations to the home, required by the waiver 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 participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department.* (7-1-06)T~~

~~***11. Specialized Medical Equipment and Supplies***. *Specialized medical equipment and supplies consist of devices, controls, or appliances, specified in the Plan of Care which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items,*~~

~~and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds will be in addition to any medical equipment and supplies furnished under the State Plan and will exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (7-1-06)T~~

~~**12. Personal Emergency Response Systems (PERS)**. PERS may be provided to monitor waiver participant safety and provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (7-1-06)T~~

~~**13. Home Delivered Meals**. Home delivered meals consist of meals designed to promote adequate waiver participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day, and who have no regular caretaker for extended periods of time. (7-1-06)T~~

~~**14. Extended State Plan Services**. Extended State 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 Plan. Under the waiver, therapy services will include: (7-1-06)T~~

~~**a.** Services provided in the waiver participant's residence, day rehabilitation site, or supported employment site; (7-1-06)T~~

~~**b.** Consultation with other service providers and family members; (7-1-06)T~~

~~**c.** Participation on the participant's Plan of Care team. (7-1-06)T~~

~~**15. 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 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 or nutritional supplements which are to be administered on a continuous or daily basis, injections, blood glucose monitoring, and blood pressure monitoring. (7-1-06)T~~

~~**16. Personal Care Services**. Services consist of assistance due to a medical condition which impairs physical or mental function and which maintains a participant safely and effectively in 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.* (7-1-06)T~~

~~***17. Behavior Consultation or Crisis Management**. Behavior consultation or crisis management consist of services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis.* (7-1-06)T~~

~~***18. 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 participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week unless provided as an adjunct to other day activities included in a participant's Plan of Care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical, occupational, or speech therapies listed in the Plan of Care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.* (7-1-06)T~~

~~***19. Place of Service Delivery**. Waiver services for participants with a traumatic brain injury may be provided in the participant's personal residence, 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:* (7-1-06)T~~

~~***a.** Excluded as a Personal Residence.* (7-1-06)T~~

~~*i. Licensed Skilled, or Intermediate Care Facilities, Certified Nursing Facility (NF) or hospital; and* (7-1-06)T~~

~~*ii. Licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR); and* (7-1-06)T~~

~~*iii. Residential Care or Assisted Living Facility.* (7-1-06)T~~

~~***b.** Additional Service Limitations. Additional limitations to specific services are listed under that service definition.* (7-1-06)T~~

~~***341. TBI WAIVER SERVICES - PROCEDURAL REQUIREMENTS.***~~

~~***01. Service Delivered Following a Written Plan of Care**. All waiver services must be authorized by the Regional Medicaid Services in the region where the participant will be residing and provided based on a written Plan of Care.* (7-1-06)T~~

~~***a.** Development of the Plan of Care. The Plan of Care is developed by the Plan of Care team which includes:* (7-1-06)T~~

~~*i. The Waiver Participant. Efforts must be made to maximize the participant's participation on the team by providing him with information and education regarding his rights; and* (7-1-06)T~~

~~*ii. The Department's administrative case manager; and* (7-1-06)T~~

~~*iii. The guardian when appropriate; and* (7-1-06)T~~

~~*iv. May include others identified by the waiver participant.* (7-1-06)T~~

~~***b.** Assessment Process Approved by the Department. The Plan of Care must be based on an assessment process approved by the Department.* (7-1-06)T~~

~~***c.** Included in the Plan of Care. The Plan of Care must include the following:* (7-1-06)T~~

~~*i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; and* (7-1-06)T~~

~~*ii. Supports and service needs that are to be met by the participant's family, friends and other community services; and* (7-1-06)T~~

~~*iii. The providers of waiver services when known; and* (7-1-06)T~~

~~*iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and* (7-1-06)T~~

~~*v. The signature of the participant or his legal representative and the case manager.* (7-1-06)T~~

~~*vi. The plan must be revised and updated by the Plan of Care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually.* (7-1-06)T~~

~~***d.** Authorization of Services. All services reimbursed under the Home and Community Based Waiver for participants with a traumatic brain injury must be authorized prior to the payment of services by the Regional Medicaid Services.* (7-1-06)T~~

~~***e.** Service Supervision. The Plan of Care which includes all waiver services is monitored by the Department's case manager.* (7-1-06)T~~

~~***02. Provider Records**. Three (3) types of record information will be maintained on all participants receiving waiver services:* (7-1-06)T~~

~~***a.** Service Provider Information. Direct Service Provider Information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information:* (7-1-06)T~~

~~*i. Date and time of visit; and* (7-1-06)T~~

~~*ii. Services provided during the visit; and* (7-1-06)T~~

~~*iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and* (7-1-06)T~~

~~*iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Case manager to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record.* (7-1-06)T~~

~~*v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Regional Medicaid Services. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services.* (7-1-06)T~~

~~***b.*** *Plan of Care. The Plan of Care which is initiated by the Regional Medicaid Services and developed by the case manager and the Plan of Care team must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 341.01 of these rules and a copy of the most current Plan of Care will be maintained in the participant's home and will be available to all service providers and the Department.* (7-1-06)T~~

~~***c.*** *Verification of Services Provided. In addition to the Plan of Care, at least monthly the case manager will verify in writing that the services provided were consistent with the Plan of Care. Any changes in the plan will be documented and include the signature of the case manager and when possible, the participant.* (7-1-06)T~~

~~***03. Records Maintenance****. In order to provide continuity of services, when a participant is transferred among service providers, or when a participant changes case managers, all of the foregoing participant records will be delivered to and held by the Regional Medicaid Services until a replacement service provider or case manager assumes the case. When a participant leaves the waiver services program, the records will be retained by the Regional Medicaid Services as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for three (3) years following the date of service.* (7-1-06)T~~

~~***04. Provider Responsibility for Notification****. It is the responsibility of the service provider to notify the case manager when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record.* (7-1-06)T~~

~~***342. TBI WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.*** *All providers of waiver services must have a valid provider agreement or performance contract with the Department. Performance under this agreement or contract will be monitored by the Regional Medicaid Services in each region.* (7-1-06)T~~

~~**01. Residential Habilitation Service Providers**. Providers of residential habilitation services must meet the following requirements: (7-1-06)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 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 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. (7-1-06)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 participant. Skill training may be provided by a Program Coordinator, if no agency is available in their geographic area as outlined in Subsection 342.01.c of these rules, who has demonstrated experience in writing skill training programs. Additional training requirements may also include: 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. (7-1-06)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 service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (7-1-06)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 certified family home. Non-compliance with the above standards will be cause for termination of the provider's provider agreement/contract. (7-1-06)T~~

~~**02. Chore Service Providers**. Providers of chore services must meet the following minimum qualifications: (7-1-06)T~~

~~**a.** Be skilled in the type of service to be provided; and (7-1-06)T~~

~~**b.** Demonstrate the ability to provide services according to a Plan of Care (7-1-06)T~~

~~**03. Respite Care Service Providers**. Providers of respite care services must meet the following minimum qualifications: (7-1-06)T~~

~~*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 or the family or guardian;* (7-1-06)T~~

~~*b. Have received care giving instructions in the needs of the person who will be provided the service;* (7-1-06)T~~

~~*c. Demonstrate the ability to provide services according to a Plan of Care;* (7-1-06)T~~

~~*d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people;* (7-1-06)T~~

~~*e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services;* (7-1-06)T~~

~~*f. Be free of communicable diseases; and* (7-1-06)T~~

~~*g. Have successfully completed a traumatic brain injury training course approved by the Department.* (7-1-06)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 traumatic brain injury training course approved by the Department.* (7-1-06)T~~

~~*05. **Transportation Service Providers**.Transportation service providers must:* (7-1-06)T~~

~~*a. Possess a valid driver's license; and* (7-1-06)T~~

~~*b. Possess valid vehicle insurance.* (7-1-06)T~~

~~*06. **Environmental Modifications Service Providers**. Environmental Modifications services must:* (7-1-06)T~~

~~*a. Be done under a permit, if required; and* (7-1-06)T~~

~~*b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes.* (7-1-06)T~~

~~*07. **Specialized Medical Equipment and Supplies**. Specialized Medical Equipment and Supplies purchased under this service must:* (7-1-06)T~~

~~*a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and* (7-1-06)T~~

~~*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.* (7-1-06)T~~

~~***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.* (7-1-06)T~~

~~***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:* (7-1-06)T~~

~~***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;* (7-1-06)T~~

~~***b.** Maintain Registered Dietitian documented review and approval of menus, menu cycles and any changes or substitutes;* (7-1-06)T~~

~~***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;* (7-1-06)T~~

~~***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;* (7-1-06)T~~

~~***e.** Provide documentation of current driver's license for each driver; and* (7-1-06)T~~

~~***f.** Must be inspected and licensed as a food establishment by the District Health Department.* (7-1-06)T~~

~~***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 traumatic brain injury training course approved by the Department.* (7-1-06)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 traumatic brain injury training course approved by the Department.* (7-1-06)T~~

~~***12. Behavior Consultation or Crisis Management Service Providers**. Behavior Consultation or Crisis Management Providers must meet the following:* (7-1-06)T~~

~~***a.** Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; or* (7-1-06)T~~

~~***b.** Be a licensed pharmacist; or* (7-1-06)T~~

~~**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 (7-1-06)T*~~

~~**d.** *Take a traumatic brain injury training course approved by the Department. (7-1-06)T*~~

~~**e.** *Emergency back-up providers must also meet the minimum provider qualifications under Residential Habilitation services. (7-1-06)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 traumatic brain injury course approved by the Department. (7-1-06)T*~~

~~**14. Personal Care Service Providers**. *Personal Care Service providers must meet the requirements outlined in Section 305 of these rules for PCS Provider Qualifications. Providers must take a traumatic brain injury training course approved by the Department. (7-1-06)T*~~

~~**343. TBI WAIVER SERVICES - PAYMENT METHODOLOGY.**~~
~~*The following outlines the criteria used in reimbursing providers for waiver services. (7-1-06)T*~~

~~**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. (7-1-06)T*~~

~~**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. (7-1-06)T*~~

~~**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 participant's home or other service delivery location when the participant is not being provided transportation. (7-1-06)T*~~

3~~44~~35. -- 449. (RESERVED).