HOUSE HEALTH AND WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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IDAPA 15 - OFFICE OF THE GOVERNOR

IDAHO COMMISSION ON AGING

15.01.02 - RULES GOVERNING AREA AGENCY ADULT PROTECTION PROGRAMS

DOCKET NO. 15-0102-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 39-5312, 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 July 4, 2007 Idaho Administrative Bulletin, Vol. 07-7, pages 42 through 44.

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 Kim Toryanski, Administrator at (208) 334-3833 x 228.

DATED this 26th day of July, 2007.

Lois S. Bauer
Administrator
Idaho Commission on Aging
3380 Americana Terrace, Ste. 120
Boise, Idaho 83706
(208) 334-3833 x 228 phone
(208) 334-3033 fax

COMMISSION ON AGING ***Docket No. 15-0102-0701***
Area Agency Adult Protection Programs ***PENDING RULE***

THE FOLLOWING NOTICE 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 39-5312, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 18, 2007.

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

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

The proposed rules are necessary to further define an "AP (Adult Protection) worker" and to reflect that definition in the rules regarding administrative requirements. Existing IDAPA 15.01.02.010.02 provides that only social workers licensed in the state of Idaho may act as AP workers. However, the issues faced by AP workers have become much more complex, often involving mental health issues and substance abuse issues. Expanding the definition of an "AP worker" to include other qualified individuals with relevant education and experience will provide an opportunity to establish an AP work force with a greater depth of experience to meet the challenges presented in today's AP investigations.

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:

There is no fiscal impact to the general fund resulting from this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because of the pressing need for an AP workforce qualified to conduct complex AP investigations.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Lois S. Bauer, Administrator at (208) 334-3833 x 228.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 25, 2007.

DATED this 16th day of May, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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

01. Adult Protection (AP). Statutory protections safeguarding vulnerable adults through investigations of reports alleging abuse, neglect, self-neglect or exploitation, and arrangements for the provision of emergency or supportive services necessary to reduce or eliminate risk of harm. (7-1-98)

02. AP Supervisor. AAA employee responsible for overseeing the provision of AP services. The Supervisor's duties include the direct supervision of AP staff, case assignments, the monitoring of case loads and documentation, and the maintenance of cooperative relationships with other agencies, organizations or groups serving vulnerable "at risk" populations. The employee shall be a social worker licensed to practice in Idaho. (5-3-03)

03. AP Worker. AAA employee providing AP services. The worker's duties include the investigation of AP reports, client risk assessment and the development of plans for protective actions, supportive services and/or law enforcement referral. The employee shall be any one (1) of the following: (____)

a. A social worker licensed to practice in Idaho~~.~~;or ~~(5-3-03)~~(____)

b. An individual with a BA or BS in a human services field or equivalent and at least two (2) years' experience in direct service delivery to vulnerable adults; or (____)

c. An individual with an AA or AS degree and at least two (2) years' experience in law enforcement. (____)

04. Serious Injury or Serious Imposition of Rights. A situation of substantiated abuse or neglect involving serious mental or physical injury, or exploitation. (5-3-03)

05. Protective Action Plan (PAP). An individual plan addressing the remedial, social, legal, medical, educational, mental health or other services available to reduce or eliminate the risk of harm to a vulnerable adult. A PAP may include a Supportive Services Plan as defined in IDAPA 15.01.01, "Rules Governing Idaho Senior Services Program." (5-3-03)

06. Serious Physical Injury. Includes, but is not limited to: (3-30-01)

a. Severe skin bruising; (5-3-03)

b. Burns; (3-30-01)

c. Bone fractures; (3-30-01)

d. Decubitis ulcers; (5-3-03)

e. Internal injuries; (5-3-03)

f. Lacerations; (3-30-01)

g. Malnutrition resulting in serious medical consequences; (5-3-03)

h. Subdural hematoma; or (5-3-03)

i. Soft tissue swelling. (5-3-03)

(BREAK IN CONTINUITY OF SECTIONS)

021. ADMINISTRATIVE REQUIREMENTS.
In accordance with Section 67-5011, Idaho Code, the ICOA shall administer AP services through contracts with AAAs. Each AAA shall adhere to all administrative requirements relating to AP programs and those enumerated in IDAPA 15.01.01, "Rules Governing Senior Services Program," unless a waiver is granted by the ICOA. (4-6-05)

01. Staffing. Each AAA shall provide sufficient staffing to respond to AP complaints within the statutory time frames set forth in Section 39-5304 (2), Idaho Code. (7-1-98)

02. Employee Qualifications. Each AAA shall adhere to standards set forth in rule for the education and licensing of AP program employees, including requirements for the AP Supervisor, AP Worker and Supportive Services Technician. ~~*Any person hired after July 1, 1998, to fill the position of AP Supervisor or AP Worker shall be a social worker licensed to practice in Idaho.* *(7-1-98)*~~(____)

03. Program Reporting and Records. All AAA AP programs shall comply with the ICOA's requirements for reporting and investigative documentation, and shall utilize standardized forms provided by the ICOA. (7-1-98)

04. Conflict of Interest. AP program employees and their immediate families shall not hold a financial interest in agencies, organizations and entities providing care for vulnerable adults. (7-1-98)

05. Program Reviews. Upon prior notice and at reasonable intervals determined by ICOA, ICOA shall conduct on site program reviews of AAA AP programs. (7-1-98)

IDAPA 15 - OFFICE OF THE GOVERNOR

COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.01 - FEDERAL LAWS AND REGULATIONS

DOCKET NO. 15-0201-0701 (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 2008 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 67-5407(e), 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 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, page 302. The rule is being repealed in it entirety.

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 Trina Ayres, Management Assistant, at (208) 639-8369.

DATED this 1st day of November, 2007.

Trina Ayres
Management Assistant
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
P. O. Box 83720
Boise, Idaho 83720-0012
(208) 639-8369 phone
(208) 334-2963 fax

THE FOLLOWING NOTICE 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 67-5407(e), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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, promulgated in 1985 and since unchanged, is outdated, inaccurate, and unnecessary. The ICBVI seeks to repeal the entire chapter.

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 prior to the publication of the proposed rule because the existing chapter of rules is inaccurate and unncecessary and is being repealed.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Trina Ayres, Management Assistant, at (208) 639-8369.

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 24, 2007.

DATED this 15th day of August 2007.

IDAPA 15.02.01 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 15 - OFFICE OF THE GOVERNOR

COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.02 - VOCATIONAL REHABILITATION SERVICES

DOCKET NO. 15-0202-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 67-5407(e) and 67-5408, 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.

Various Sections, Subsections, and Paragraphs have been amended replacing the acronym "VR" with the words "vocational rehabilitation."

Various Subsections and Paragraphs have been amended replacing the acronym "ICBVI" and "ICBVI's" with the word(s) "Commission," "the Commission," or "the Commission's."

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 Book 1 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 303 through 318.

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 pending rule, contact Trina Ayres, Management Assistant, at (208) 639-8369.

DATED this 1st day of November, 2007.

Trina Ayres
Management Assistant
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
P. O. Box 83720
Boise, Idaho 83720-0012
(208) 639-8369 phone
(208) 334-2963 fax

THE FOLLOWING NOTICE 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 67-5407(e) and 67-5408, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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

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

To promulgate rules governing the Commission's provision of vocational rehabilitation services to its clients as provided by Section 67-5408, Idaho Code, and in accordance with the Rehabilitation Act of 1973, its 1998 amendments, and related federal regulations. The Commission currently has established rules governing its provision of Vocational Rehabilitation Services located at IDAPA 15.02.02. The Commission also has its 2007 Vocational Rehabilitation Policy Manual, which includes many procedural and practice requirements relating to its provision of Vocational Rehabilitation Services to its clients. The Commission desires to update its rules at IDAPA 15.02.02 to include those provisions contained in its 2007 Policy Manual that should be included in its IDAPA rules governing its provision of Vocational Rehabilitation Services. The Commission also seeks to promulgate rules to incorporate by reference all applicable federal laws and regulations governing its provision of Vocational Rehabilitation Services and provide for additional rules concerning written interpretations, public records, and office information.

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 prior to the publication of the proposed rule because the proposed rule allows the provision of benefits to the identifiable interested parties.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Trina Ayres, Management Assistant, at (208) 639-8369.

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 24, 2007.

DATED this 28th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
~~*The Board of the Commission for the Blind and Visually Impaired, pursuant to authority granted in Title 67, Chapter 54*~~ This chapter is adopted in accordance with Sections 67-5407(e) and 67-5408, Idaho Code~~*, did adopt the following as policy for the administration of vocational rehabilitation services to the blind of Idaho*~~. ~~*(1-5-87)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

002. WRITTEN INTERPRETATIONS.
Field manuals and other agency guidance documents, as well as agency policy statements or interpretations not rising to the legal effect of a rule, if any, are available for inspection and copying at the Commission offices during regular business hours. (____)

003. ADMINISTRATIVE APPEALS.
Administrative appeals shall be governed by Section 355 of these rules in accordance with 34 CFR Part 361.57. (____)

004. INCORPORATION BY REFERENCE.
The following federal laws and regulations are incorporated by reference into the rules of this chapter and copies are available at the Commission's office: (____)

01. 29 U.S.C. Section 701, et seq., Rehabilitation Act of 1973 as Amended in 1998. (____)

02. **34 CFR Parts 361 *and* 363**. *(____)*

005. **OFFICE - OFFICE HOURS - MAILING ADDRESS AND STREET ADDRESS.**
The principal place of business of the Idaho Commission for the Blind and Visually Impaired is in Boise, Idaho. The office is located at 341 West Washington Street, Boise, Idaho and is open from 8 a.m. to 5 p.m., except Saturday, Sunday, and legal holidays. The mailing address is: P. O. Box 83720, Boise, Idaho 83720-0012. The telephone number of the office is (208)334-3220. The facsimile number of the office is (208)334-2963. (____)

006. **PUBLIC RECORDS ACT COMPLIANCE.**
Commission records are subject to the provisions of the Idaho Public Records Act, Title 9, Chapter 3, Idaho Code. (____)

***~~350~~ 007*. CONFIDENTIALITY.**
All ~~P~~personal information ~~*the Commission for the Blind and Visually Impaired has regarding any individual who is or may become legally blind, and who is or may become legally blind, and who is or may be a referral, or former client, is and will be treated as*~~ concerning clients is confidential ~~*information*~~. The information is used only for purposes directly connected to the *Commission's* administration of *Vocational Rehabilitation Services*, and may not be released without the informed, written consent of the client except as otherwise provided by law.
~~*(1-5-87)*~~*(____)*

00*8*. -- 009. **(RESERVED).**

010. **DEFINITIONS.**

01. **Blind or Visually Impaired**. A person whose visual acuity with correcting lenses is not better than twenty/two hundred (20/200) in the better eye; or a person whose vision in the better eye is restricted to a field which subtends an angle of not greater than twenty (20) degrees; or a person who is functionally blind; or a person who is without any sight. (____)

02. **Client**. An individual who has applied for, or is determined to be eligible for, vocational rehabilitation services. (____)

03. **Commission**. The Idaho Commission for the Blind and Visually Impaired. (____)

04. **Comprehensive Assessment**. An assessment of the personality, interests, interpersonal skills, intelligence and related functional capacities, educational achievements, work experience, vocational aptitudes, personal and social adjustments, and employment opportunities of the individual and the medical, psychiatric, psychological, and other pertinent vocational, educational, cultural, social, recreational, and environmental factors that affect the employment and rehabilitation needs of the individual. An assessment also includes, to the degree needed, an appraisal of the patterns of work behavior of the individual and services needed for the individual to acquire occupational skills and to develop work attitudes, work habits, work tolerance, and social and behavior patterns necessary for successful job performance, including the use of work in real job situations to assess and develop the capabilities of the individual to perform adequately in a work environment. (____)

05. **Comparable Benefits or Services**. Any benefit or service that exists under any other programs that is available to the client. Examples are, but not limited to, Pell Grants, Medicaid, Medicare, private health insurance, and medical indigence programs for medication. ( )

06. **Designated State Unit**. Idaho Commission for the Blind and Visually Impaired. ( )

07. **Functionally Blind**. A person with a visual impairment which constitutes or results in a substantial impediment to employment or substantially limits one (1) or more major life activities. This is determined by the vocational rehabilitation counselor, not a physician. ( )

08. **Maintenance**. Monetary support provided to an individual for expenses, such as food, shelter, and clothing, that are in excess of the normal expenses of the individual and that are necessitated by the client's participation in an assessment for determining eligibility and vocational rehabilitation needs or the client's receipt of vocational rehabilitation services under an individualized plan for employment (34 CFR Part 361.5(35)). ( )

09. **Vocational Rehabilitation Service or Services**. Services that reduce the impact of functional limitations on the ability of a client to achieve an employment outcome. ( )

011. **ABBREVIATIONS.**

01. **ATC**. Assessment and Training Center. ( )

02. **CFR**. Code of Federal Regulations. ( )

03. **IPE**. Individual Plan for Employment. ( )

04. **SSDI**. Social Security Disability Insurance. ( )

05. **SSI**. *Supplemental* Security Income. ( )

0~~0~~1~~1~~2. -- 099. (RESERVED).

~~100. POPULATION TO BE SERVED.~~
~~The following defined individuals will be served by the Idaho Commission for the Blind and Visually Impaired.~~ *~~(1-5-87)~~*

~~01. Legally Blind~~*~~. Individuals who have been determined legally blind as defined in Section 67-5402 of the Idaho Code.~~* *~~(1-5-87)~~*

~~02. Handicap to Employment~~*~~. As a result of the disability, a substantial handicap to employment is imposed.~~* *~~(1-5-87)~~*

~~03. Return To or Obtaining Employment~~*~~. Following the services of the Idaho Commission for the Blind and Visually Impaired, that person will be able to obtain or return to~~*

~~*gainful employment.*~~ ~~*(1-5-87)*~~

~~***04. Financial Needs Determination**. The counselor and eligible individuals will complete an individualized written rehabilitation plan. A financial needs determination will be made in each case before the services can be provided, and all available similar benefits shall be explored and utilized.*~~ ~~*(1-5-87)*~~

10~~1~~0. PROVISION OF SERVICES ON A STATEWIDE BASIS.
~~*All*~~ Vocational Rehabilitation ~~s~~Services ~~*of the Commission for the Blind and Visually Impaired*~~ are offered on a statewide basis to individuals who are blind or visually impaired or functionally blind, subject to eligibility. ~~*(1-5-87)*~~(____)

101. APPLICATION.
Any blind *or* visually impaired or functionally blind individual may apply for vocational rehabilitation services. To apply for vocational rehabilitation services, such an individual must: (____)

01. Application. Meet with a *vocational rehabilitation* counselor and sign the application. An individual is considered to have applied for vocational rehabilitation services with the *Commission* when that individual has completed the application and acknowledged client rights and responsibilities. (____)

02. Evidence. Assist in providing medical and psychological reports to substantiate disability and functional limitations. If the client is an SSA beneficiary, assist in providing evidence of receipt of SSA benefits. (____)

03. Availability. Be available to complete assessment process. (____)

04. Partner. Be an active and full partner in the vocational rehabilitation process. (____)

05. Intention. Intend to achieve an employment outcome. (____)

102. -- 109. (RESERVED).

110. ELIGIBILITY.
~~*Eligibility shall be based upon the determination of a disability as defined in Section 100, "Population To Be Served," and such disability for the individual constitutes or results in a substantial handicap to employment; and a reasonable expectation exists that vocational rehabilitation services may benefit the individual in terms of employability.*~~ ~~*(1-5-87)*~~

01. Eligibility Requirements. Eligibility ~~*requirements will be applied*~~ of a client for vocational rehabilitation services shall be based upon a determination by the Commission ~~*for the Blind and Visually Impaired without regard to sex, race, age, creed, color, physical or mental handicap, sexual orientation, or national origin of the individual applying for services.*~~ that: ~~*(1-5-87)*~~(____)

a. The client is blind or visually impaired; (____)

b. The client's blindness or visual impairment constitutes or results in a substantial impediment to employment; *and* *(____)*

c. There is a reasonable expectation that vocational rehabilitation services will benefit the client in terms of securing, retaining, or regaining employment. (____)

02. Residency Requirements. ~~*A residence requirement, duration or other, will not be applied by the Commission for the Blind and Visually Impaired as a condition of eligibility*~~ A client must have legal residence status, be able to complete an employment eligibility verification, and be present in the state. ~~*(1-5-87)*~~(____)

03. ~~***Preliminary Diagnostic Study***. *A financial needs determination will be made in each case, and all similar benefits will be explored and utilized prior to the expenditure of funds.*~~ **Presumptive Eligibility**. Individuals who are current SSI or SSDI beneficiaries are presumed to be eligible for vocational rehabilitation services unless the *Commission* can demonstrate by clear and convincing evidence that such individuals are incapable of benefiting in terms of an employment outcome from vocational rehabilitation services due to the severity of their disability. ~~*(1-5-87)*~~(____)

~~***04. Financial Needs Determination***. *A financial needs determination will be made in each case, and all similar benefits will be explored and utilized prior to the expenditure of funds.* *(1-5-87)*~~

0~~5~~4. Certificate of Ineligibility. If an individual is determined ineligible for services, a certificate of ineligibility will be prepared and a copy provided the individual or the individual's representative. ~~*(1-5-87)*~~(____)

~~***06. Annual Review***. *An annual review will be done of those cases meeting the annual review requirements.* *(1-5-87)*~~

111. RESERVING ALL ELIGIBILITY DECISIONS AND NATURE AND SCOPE OF SERVICES.
The Commission ~~*for the Blind and Visually Impaired*~~ has the sole responsibility for determining eligibility ~~*that will provide services to all eligible individuals who are legally blind*~~ of clients. Eligibility will be determined within a reasonable period of time, not to exceed sixty (60) days, after a client has submitted an application for services unless exceptional and unforeseen circumstances beyond the control of the Commission preclude making an eligibility determination within sixty (60) days and the Commission and the client agree to a specific extension of time or the Commission is exploring an individual's abilities, capabilities, and capacity to perform in work situations. Eligibility requirements will be applied by the Commission without regard to sex, race, age, creed, color, physical or mental disability, sexual orientation, or national origin of the individual applying for services. ~~*(1-5-87)*~~(____)

~~***112. – 149. (RESERVED).***~~

~~***150. ECONOMIC NEEDS TEST.***~~
~~*Blind persons receiving services from the Commission for the Blind and Visually Impaired and*~~

~~*who possess the financial resources to do so will be required to participate in the payment for assistance provided. An economic needs test shall be explored by the blind client and his/her counselor.* *(1-5-87)*~~

~~***01. Diagnostic Services****. An economic needs test will not be applied as a condition for furnishing the following vocational rehabilitation services: Diagnostic services for the evaluation for rehabilitation potential, counseling, guidance, referral, and no cost placement.* *(1-5-87)*~~

~~***02. Supplemental Security Income (SSI) or Public Assistance****. An economic needs test shall not be required for those individuals who are recipients of Supplemental Security Income (SSI) or public assistance.* *(1-5-87)*~~

~~***03. Nonresident****. Any nonresident attending the Orientation and Adjustment Center will be charged tuition. This cost will be determined upon the average cost of providing services to those in the Orientation and Adjustment Center.* *(1-5-87)*~~

~~***151. -- 199. (RESERVED).***~~

~~***200. EVALUATION OF VOCATIONAL REHABILITATION POTENTIAL.***~~
~~*For every applicant for vocational rehabilitation services, the Commission for the Blind and Visually Impaired will provide the following services in the order given. If at any point in the below order of services an applicant is found ineligible, no further services will be provided.* *(1-5-87)*~~

~~***01. Visual Condition****. An evaluation of visual condition to determine if the applicant is legally blind;* *(1-5-87)*~~

~~***02. Handicap to Employment****. An evaluation of the handicap to employment caused by the loss of vision;* *(1-5-87)*~~

~~***03. Employment Ability****. An evaluation of the individual's ability to benefit from vocational rehabilitation services in terms of employment;* *(1-5-87)*~~

~~***04. Rehabilitation Services Needed****. An assessment of the scope and nature of vocational rehabilitation services necessary for an individual to reach a suitable vocational objective.* *(1-5-87)*~~

~~*20*~~11<u>2</u>. -- 209. (RESERVED).

210. INDIVIDUAL~~*IZED WRITTEN REHABILITATION*~~ PLAN <u>FOR EMPLOYMENT</u>.
For those ~~*individuals found*~~ <u>clients determined</u> eligible ~~*or acceptable*~~ for <u>vocational</u> rehabilitation services, an ~~*individualized written rehabilitation plan will*~~ <u>IPE shall</u> be developed between the ~~*blind individual*~~ <u>client</u> and their <u>*vocational rehabilitation*</u> counselor. <u>An approved IPE or IPE amendment must be signed by the client or the client's representative and appropriate Commission staff in order to be implemented. Services may be discontinued if the client fails to participate actively or does not make adequate progress toward plan completion.</u> ~~*The individualized written rehabilitation plan will consist of*~~ <u>Prior to the IPE being written, a comprehensive assessment is required to evaluate the following components</u>: ~~*(1-5-87)*~~<u>( )</u>

01. ~~***Determination****. The basis on which the determination of eligibility has been made. In those cases where a person has been found acceptable, an extended evaluation of vocational rehabilitation potential is necessary to make a determination of eligibility.*~~ **Employment Outcome**. To determine the employment outcome that is selected by the client, with input from the *vocational rehabilitation* counselor, that is consistent with the client's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. ~~*(1-5-87)*~~(____)

a. Provisions of Community Rehabilitation Program Services. The Commission will purchase vocational rehabilitation services from community rehabilitation programs that are accredited by either the Commission on Accreditation of Rehabilitation Facilities (CARF), the Rehabilitation Accreditation Commission, or Rehabilitation Services Accreditation System. In conjunction with the client, the *vocational rehabilitation* counselor will determine which, if any, community rehabilitation program services are required for the client to achieve an employment outcome. (____)

02. ~~***Objectives****. The long range and intermediate rehabilitation objectives established for the individual.*~~ **Nature and Scope**. To identify the nature and scope of the vocational rehabilitation services that the client needs to become employed. ~~*(1-5-87)*~~(____)

03. ~~***Specific Vocational Rehabilitation Services****. The determination of the specific vocational rehabilitation services to be provided in order to achieve the established rehabilitation objectives.*~~ **Planned Services**. To determine how the planned services will assist the client in overcoming the barriers to employment that were identified in the eligibility determination. ~~*(1-5-87)*~~(____)

04. ~~***Initiation and Duration Date****. The projected date for the initiation of each vocational rehabilitation service, and the anticipated duration of each service;*~~ **Costs**. The client must apply for and secure any Comparable benefits or services, participate in paying for any or all costs of the IPE services, and make a commitment to cooperate and follow through with the IPE and achieve an employment outcome. Clients receiving services wherein costs are incurred and who possess the financial resources to do so will be required to participate in the payment for assistance provided them. ~~*(1-5-87)*~~(____)

~~***05.*** ***Review and Evaluation****. A procedure and schedule for periodic review and evaluation of progress toward achieving rehabilitation objectives based upon objective criteria and a record of these reviews and evaluations. (1-5-87)***~~

~~***06.*** ***Client Opinion****. The views of the blind individual, or, as appropriate, his/her parent, guardian, or other representative, concerning his/her goals and objectives and the vocational rehabilitation services being provided. (1-5-87)***~~

~~***07.*** ***Terms and Conditions****. The terms and conditions for the provision of vocational rehabilitation services including responsibilities of the blind individual in implementing the individualized written rehabilitation plan, the extent of client participation in the cost of services if any, the extent to which the individual is eligible for similar benefits under any other programs and the extent to which these similar benefits have been used. (1-5-87)***~~

~~***08. Client Rights**. An assurance that the blind individual has been informed of his/her rights and the means by which he/she may express and seek remedy for any dissatisfaction, including the opportunity for an administrative review of Commission for the Blind and Visually Impaired action, fair hearing, or review by the Secretary of the U.S. Department of Education. (1-5-87)***~~

~~***09. Provision of Explanation**. Where appropriate, assurance that the blind individual has been provided a detailed explanation of the availability of the resources within a client assistance project. (1-5-87)***~~

~~***10. Basis for Determination**. The basis on which the individual has been determined to be rehabilitated. (1-5-87)***~~

~~***11. Post-Employment Services**. Any plans for the provision of post-employment services after a suitable employment goal has been achieved and the basis on which such plans are developed. (1-5-87)***~~

~~***211. – 249. (RESERVED).***~~

~~***250. VOCATIONAL REHABILITATION SERVICES TO INDIVIDUALS.***~~

~~***01. Counseling and Guidance**. All clients and other interested parties will be provided information on blindness and vocational adjustment of blind individuals. (1-5-87)***~~

~~***a.** For clients, the counselor of the Commission for the Blind and Visually Impaired will provide at the initial contact a full explanation of eligibility requirements and related procedures and services available through the Commission for the Blind and Visually Impaired for eligible clients. The counselor, at this time, will initiate a counselor, at this time, will initiate a counseling relationship that will last throughout the course of the individual's contact with the Commission for the Blind and Visually Impaired, designated to accomplish the client's successful adjustment to his/her situation. (1-5-87)***~~

~~***b.** At appropriate times during the vocational rehabilitation process, referral will be made to other agencies that might provide useful services. (1-5-87)***~~

~~***c.** Counseling and guidance will be offered to family members and other individuals regarding blindness when it is determined that such assistance will be beneficial to the client. (1-5-87)***~~

~~***02. Physical and Mental Restoration**. After making a determination that the condition is stable or slowly progressive, the Commission for the Blind and Visually Impaired will provide physical and/or mental restoration services that will enhance the client's rehabilitation potential. Of primary concern is the effect the service will have on the individual reaching a suitable vocational objective. (1-5-87)***~~

~~***a.** Although determined medically advisable, the Commission for the Blind and Visually Impaired must view these services from a vocational point and it is, therefore, recognized***~~

~~that not all services stated to be medically desirable would be provided. Services provided include (but are not limited to) eye surgery, hearing aids, corrective surgery, prosthetic devices, and/or psychological or psychiatric services. (1-5-87)~~

~~**b.** In dealing with individuals who have multiple physical disabilities, the Commission for the Blind and Visually Impaired will carefully evaluate the vocational handicap caused by the physical disability other than blindness or mental disability and, if appropriate, make referral to other agencies. (1-5-87)~~

~~**c.** In cases where there exists a reasonable likelihood that the services of the Commission for the Blind and Visually Impaired will benefit the person in terms of employability, those recommendations will be reviewed by the agency medical consultant. (1-5-87)~~

~~**03. Vocational Training**. The Commission for the Blind and Visually Impaired will provide or facilitate the provision of such vocational training as is necessary for the client to reach the jointly agreed upon vocational goal stated in the client's individualized written rehabilitation plan within the following guidelines: (1-5-87)~~

~~**a.** No training in universities, colleges, vocational schools or technical schools will be paid for with rehabilitation funds unless maximum efforts have been made to secure grant assistance in whole or in part from all other known sources. (1-5-87)~~

~~**b.** Training in institutions of higher learning will be provided to the level that ordinary entry into the selected vocational field is made. (1-5-87)~~

~~**c.** Training in universities, colleges, vocational schools or technical institutes will take place within the state of Idaho unless it can be shown that training that would allow the client equal employment opportunities is not available within the State. Except for specialized training programs for the blind, in no case will the cost off attending an out-of-state facility exceed the highest cost of attending an in-state public facility. (1-5-87)~~

~~**04. Orientation and Adjustment Center Training**. The Commission for the Blind and Visually Impaired will operate and maintain an Orientation and Adjustment Center for the blind of the State and for those persons for whom, through joint planning, it is determined that the Orientation and Adjustment Center is the most suitable resource for prevocational or vocational training. The primary focus of this center will be to develop proper attitudes about blindness in the student. Hand-in-hand with this emphasis will be training in such skill areas as the long cane method of travel, Braille, typing, home economics, industrial arts, sewing and abacus. Essential to the student's development will be an understanding of the social and vocational attitudes about blindness and an awareness of how to cope with problems which will arise by reason of the negative social and vocational attitudes about blind individuals. (1-5-87)~~

~~**05. Home Instruction**. Alternative training in the areas described above is also available through the home teaching program of the Commission for the Blind and Visually Impaired or those persons who do not attend the Orientation and Adjustment Center. (1-5-87)~~

~~**06. Training Tools and Materials**. The Commission for the Blind and Visually Impaired will provide to the client books, tools and other training materials as agreed to through~~

~~*joint planning by the counselor and client. The amount of materials supplied will be dependent upon the course of study, and it is expected that different amounts would be provided to individual clients. Major pieces of equipment, such as closed circuit television magnifying systems, sensory conversion systems such as Versa Braillers, computers with voice output, etc., will not be assigned to an individual nor a training program, but rather will be assigned to the training facility and utilized by the maximum number of clients of the Commission for the Blind and Visually Impaired attending that facility.* (1-5-87)~~

~~***07.*** ***Maintenance****. Maintenance is a supportive service of the Commission for the Blind and Visually Impaired provided to allow clients to derive the full benefit of other vocational rehabilitation services. It can be provided at any time during the rehabilitation process in conjunction with other vocational rehabilitation services. The provision of maintenance will be part of the services outlined in the individualized written rehabilitation plan. If not, a memo outlining the provision of maintenance and related services will be prepared for the case file. As a supportive service, maintenance cannot be provided unless other services, excluding counseling and guidance, are being provided concurrently. The amount of maintenance will be determined by the circumstances of each client and will be governed by the following:* (1-5-87)~~

~~***a.*** *Maintenance payments may be used to cover the cost of food, shelter, clothing and other subsistence expenses.* (1-5-87)~~

~~***b.*** *Maintenance should not exceed the amount of increased expense to a client caused by engaging in a rehabilitation program.* (1-5-87)~~

~~***c.*** *When maintenance exceeds the cost of subsistence expenses determined by other public programs (i.e., Health and Welfare and SSI), a full explanation will appear on the individualized written rehabilitation plan or in the case dictation.* (1-5-87)~~

~~***d.*** *When providing maintenance for a client to meet subsistence expenses while in a travel status, the amount will not exceed the amount provided to State employees.* (1-5-87)~~

~~***e.*** *Maintenance will be provided only following a financial needs determination and after a thorough search for similar benefits has been made.* (1-5-87)~~

~~***08.*** ***Transportation****. The Commission for the Blind and Visually Impaired will pay for transportation, including per diem, while in travel status that is necessary for a client to receive diagnostic or other rehabilitation services except maintenance. The Commission for the Blind and Visually Impaired will pay for, when deemed necessary by the client and counselor, the transportation expenses of one attendant to travel with a client. Transportation may include relocation and moving expenses necessary for achieving a vocational rehabilitation objective.* (1-5-87)~~

~~***09.*** ***Services to Family Members****. The Commission for the Blind and Visually Impaired will provide services to the family members of a client after a determination has been made that such services are necessary to the vocational rehabilitation of the client. These services may be, but are not limited to the following: transportation, care of infants and children, counseling, etc.* (1-5-87)~~

~~***10. Interpreter Services for the Deaf**. The Commission for the Blind and Visually Impaired will provide interpreter service, including tactile interpreting for deaf-blind individuals, to all individuals in need of such services in order to take full advantage of diagnostic or rehabilitation services. Where appropriate, the assistance of staff of other agencies and/or facilities will be secured to assist in the rehabilitation of deaf-blind individuals. (1-5-87)***~~

~~***11. Reader Services**. Funds will be made available for reader services to any client who is enrolled in a training program directed toward achieving his/her vocational goal in which reading is required. The client and the counselor will plan jointly as to the amount of funds required to meet the client's individual reading needs for a specified period. The agreement reached will be incorporated into the client's individualized written rehabilitation plan and the client will be given written authorization specifying the amount which has been authorized and the time period encompassed in the authorization. The client will arrange for his/her readers to bill the Commission for the Blind and Visually Impaired monthly for the reader service which has actually been provided. The client is responsible for reviewing bills submitted for completeness and accuracy. (1-5-87)***~~

~~***12. Rehabilitation Teaching Services**. Rehabilitation teaching services will be available from three (3) sources: (1-5-87)***~~

~~***a.** From the Orientation and Adjustment Center (provided that it has been determined in joint planning that the Orientation and Adjustment Center is the best vehicle for prevocational or vocational training); (1-5-87)***~~

~~***b.** Through the Commission for the Blind and Visually Impaired's home teacher service for those persons who do not attend the Orientation and Adjustment Center; and (1-5-87)***~~

~~***c.** Directly from rehabilitation counselors when the other sources are temporarily unavailable. (1-5-87)***~~

~~***13. Orientation and Mobility Services**. The objective of orientation and mobility services is to develop skills, techniques, and attitudes which enable the individual to truly function independently. Such services include, but are not limited to, training in the use of the long, white cane; development of effectiveness in nonvisual communication skills including Braille, typing, etc.; training in other appropriate skills needed by the individual to fulfill his/her responsibilities in his/her home community; stimulating affirmative attitudes toward the role of blind persons in our society and their competency to function competitively; and development of readiness to accept or even insist upon equal responsibilities and privileges of citizenship. (1-5-87)***~~

~~***14. Telecommunications, Sensory and Other Technological Aids and Devices**. The Commission for the Blind and Visually Impaired will provide telecommunications, sensory and other technological aids and devices when it has been determined through joint planning that such an aid or device is required to significantly enhance employment opportunities in the area of the vocational goal stated on the client's individualized written rehabilitation plan or significantly improve an employed client's performance so that he/she would not be underemployed. All devices and aids provided under this policy, where appropriate, will be supplied to clients only by persons licensed to do so by the State or, in the cases of newly developed aids and devices, after they meet any applicable engineering or safety standards. (1-5-87)***~~

~~***15. Recruitment and Training Services to Provide New Employment Opportunities in the Fields of Appropriate Public Service Employment****. The Commission for the Blind and Visually Impaired will assist the client to find employment in the areas which are most interesting and appealing to him/her. The counselor will, however, use his/her expertise to point out job opportunities which are available in the areas of rehabilitation, health, welfare, public safety, law enforcement and other appropriate public service employment; and the Commission for the Blind and Visually Impaired will assist in the developing opportunities for practicum or other training, either paid or unpaid, in these public service areas. (1-5-87)***~~

~~***16. Placement in Suitable Employment****. The Commission for the Blind and Visually Impaired will assist the client who has completed the necessary preparations in locating and securing regular competitive employment. (7-1-93)***~~

~~***a. In all cases, competitive employment will be considered first. (1-5-87)***~~

~~***b. Consideration of sheltered employment will be made only after it is determined that competitive employment cannot be achieved within reasonable bounds. (1-5-87)***~~

~~***c. In determining suitability of employment, factors to be considered include (but are not limited to) the client's interests, training and qualifications, background, job availability, starting wage or salary, opportunity for advancement, and the client's willingness to relocate. (1-5-87)***~~

~~***17. Post Employment Services****. The Commission for the Blind and Visually Impaired will provide post employment services when it has been determined such services are necessary to maintain employment, or in the case of an individual who accepted initial employment below their capabilities, to achieve more suitable employment which must be more apt to maintain the individual in employment and which must be closely related to the existing job. (1-5-87)***~~

~~***a. If new and distinct handicapping problems have arisen or extensive rehabilitation services are required, a new individualized written rehabilitation plan will be completed. (1-5-87)***~~

~~***b. Services which are primarily supportive of other rehabilitation services, specifically maintenance and transportation, cannot be provided by themselves as post employment services. (1-5-87)***~~

~~***18. Occupational Licenses, Tools, Equipment, Initial Stocks (Including Livestock), and Supplies Necessary to Enter an Occupation or Small Business****. Occupational licenses, tools, equipment, initial stocks (including livestock), and/or supplies necessary to enter an occupation or small business will be provided by the Commission for the Blind and Visually Impaired or the Commission for the Blind and Visually Impaired will assist in the application for assistance from other agencies and/or facilities for any or all of these services, to a client who has a vocational objective stated in a jointly developed and approved individualized written rehabilitation plan that calls for them. (1-5-87)***~~

~~***a. Expenditures for these services, in some cases, may be substantial and the Commission for the Blind and Visually Impaired will assist a client in obtaining financial***~~

~~*assistance in these cases from other sources with the Commission for the Blind and Visually Impaired using rehabilitations funds mainly to deal directly with the handicap to employment caused by blindness.* *(1-5-87)*~~

~~***b.*** *In no instance will the Commission for the Blind and Visually Impaired use rehabilitation funds to purchase land, an existing or for the erection of a building, or for the purchase of intangible resources of an existing business.* *(1-5-87)*~~

~~***19.*** ***Other Goods and Services****. Other goods and services which can be reasonably expected to be of benefit in terms of employability and are not contradicted by the Rehabilitation Act as amended, the Regulations or the State Plan, may be provided, if necessary, to reach the vocational goal stated on a jointly developed and approved individualized written rehabilitation plan.* *(1-5-87)*~~

2~~5~~1. -- 299. (RESERVED).

300. ~~*RATES OF*~~ PAYMENT POLICY.
~~*The Commission for the Blind and Visually Impaired will make reasonable efforts to purchase supplies for clients' rehabilitation needs which are the most reasonable and satisfactory quality at the lowest available cost or the usual and customary charge for such services except when such practice significantly delays or interferes with the provision of vocational rehabilitation services to the client.* *(1-5-87)*~~

~~***01.*** ***Establishment of Rates****. In establishing rates of payment the Commission for the Blind and Visually Impaired will analyze the costs of other state and public agencies for the same or similar services and will consult with organizations or businesses providing such services.* *(1-5-87)*~~

0~~2~~1. Upper Limits. ~~*The Commission for the Blind and Visually Impaired reserves the right to*~~ In order to ensure a reasonable cost to *the Commission*'s vocational rehabilitation program for provision of certain enumerated services, and in accordance with 34 CFR 361.50, *the Commission* hereby establishes upper limits on ~~*any goods and*~~ dollar amounts it will contribute to clients for certain categories of services~~.~~ provided as part of an implemented IPE pursuant to Section 210 of these rules: ~~*(1-5-87)*~~(____)

a. Education expenses, including fees, tuition, and health insurance costs, for enrollment at Idaho public and private in-state colleges, vocational technical schools, universities, and other education and training institutions and including enrollment in summer school; Three thousand three hundred dollars ($3,300) per federal fiscal year. If the client receives a Pell Grant, it shall be applied first for tuition or fees before any expenditure of funds by *the Commission*. (____)

b. Education expenses, including fees and tuition, for enrollment at out-of-state colleges, universities, vocational technical schools, and other education and training institutions, and including enrollment in summer school; three thousand three hundred dollars ($3,300) per federal fiscal year. If the client receives a Pell Grant, it shall be applied first for tuition or fees before any expenditure of funds by *the Commission*. (____)

i. If the client must attend an out-of-state institution because the course of study is not offered within the state of Idaho, *the Commission*, at its discretion may pay the "usual and customary" charges for fees and tuition up to the established limits. ( )

ii. If the course of study is offered in-state, but because of the additional costs caused by the accommodation for disability, it would be more cost effective for *the Commission* to have the client attend the out-of-state educational institution, *the Commission*, at its discretion, may pay the usual and customary fees and tuition charges for the out-of-state educational institution up to the established limit. ( )

iii. If the client chooses to attend an out-of-state institution even though the course of study is offered within the state of Idaho, *the Commission* will only pay an amount equal to the maximum cost for fees and tuition, up to the established limit, at the in-state-institution offering the course of study that is closest geographically to the *Commission* regional office assisting the client. ( )

c. Books and supplies. Six hundred dollars ($600) per federal fiscal year. This limit includes expenditures for books and supplies required for attendance of summer school. ( )

d. Medical exams including written report. ( )

i. Specialist exam by M.D: Two hundred dollars ($200) plus actual cost of related procedures such as x-rays. ( )

ii. Psychological exam by licensed psychologist: Two hundred dollars ($200) plus actual cost of psychometric tests. ( )

iii. Ophthalmologist/Optometrist exam: Two hundred dollars ($200) plus actual cost of visual field exam or other necessary tests. ( )

(1) Low vision exam: One hundred twenty-five dollars ($125). ( )

(2) Follow-up low vision consultation: Fifty-five dollars ($55). ( )

(3) Eye report: Twenty-five dollars ($25). ( )

iv. Eye glasses or contact lenses: Eighty dollars ($80) for frames and the usual and customary cost for lenses and contact lenses. Seven hundred dollars ($700) for bioptics. ( )

v. Audiologist exam: Eighty-five dollars ($85). ( )

vi. Physical exam (general basic medical): Sixty-five dollars ($65). ( )

e. Psychotherapy/Counseling sessions: Up to ten (10) hourly sessions at eighty dollars ($80) per hour. ( )

f. Medication and medical supplies (including diabetic supplies): Three hundred dollars ($300) per month for up to three (3) months, during which client must apply for reduced

cost or free medication programs provided by drug companies or other sources of comparable benefits, including Medicaid, Medicare Part D, or other insurance. ( )

g. Dental work, including but not limited to cleaning, fillings, extractions, crowns, and dentures: Five hundred dollars ($500) per case. ( )

h. Transportation. ( )

i. Public conveyance (bus, van, airfare): Actual cost. ( )

ii. Transportation costs associated with personal vehicle usage with or without personal driver: One hundred dollars ($100) per month within a twenty (20) mile radius in-town commuting and two hundred dollars ($200) per month for out-of-town commuting. *the Commission* does not provide funds for a client's purchase of a motor vehicle. ( )

iii. Cab subsidy programs (Scrip) must be used by clients where available. ( )

i. Maintenance: One thousand five hundred dollars ($1,500) per federal fiscal year and no more than three hundred dollars ($300) per month. There is no limit on the number of months a client can receive maintenance up to the one thousand five hundred dollar ($1,500) limit per federal fiscal year. ( )

i. *The Commission* will not pay maintenance for basic living expenses incurred by a client that are not directly related to the client's participation in an IPE for vocational rehabilitation services. ( )

ii. Maintenance for client attendance at Assessment and Training Center (ATC): Three hundred dollars ($300) per ATC term for basic living expenses incurred during the ATC term which are directly related to client's ATC attendance and participation. ( )

j. Copy fees: Fifteen dollars ($15) for obtaining a copy of any report or other record from an outside agency or entity required by *the Commission* in order to determine a client's eligibility or otherwise provide vocational rehabilitation services. ( )

k. Tools and equipment: One thousand dollars ($1,000) per case. Value of tools and equipment provided to client from existing *Commission* inventory will count towards the one thousand dollar ($1,000) limit. If there is a change in client's employment outcome, the client shall return the original tools and equipment to *the Commission*. *the Commission* will not provide or purchase additional tools or equipment for the client for any new employment outcome until the original tools and equipment have been returned to *the Commission*. ( )

l. On-the-Job training fees: Three thousand dollars ($3,000). ( )

m. Computers including hardware and software: One thousand dollars ($1,000) per case. If *the Commission* determines that a change in computers is necessary, the client shall return the original computer to *the Commission*. *The Commission* will not provide or purchase a new or different computer for the client until the original computer has been returned. ( )

n. Self-employment plans: Three thousand dollars ($3,000). ( )

o. Child care: Three hundred dollars ($300) per child per month. The client shall apply and use Department of Health and Welfare child care funding as a comparable benefit before any expenditure of *Commission* funds towards IPE related child care. ( )

02. Exclusion of Surgery and Organ Transplantation. ( )

a. *The Commission* does not provide funds for a client's surgery when the surgery is the only service required for the client to achieve an employment outcome or otherwise return to work. ( )

b. *The Commission* does not provide funds for a client's organ transplantation.( )

03. Authorization to Purchase. When purchasing services from a vendor, the *Commission* requires a written authorization be issued prior to, or on the beginning date of, service. If services are provided without an approved written authorization to purchase, the *Commission* reserves the right to refuse payment on the vendor's invoice. Verbal authorization for a service may only be given by the rehabilitation services chief or the *Commission* administrator. If a client fails to show up for an appointment, the client shall be responsible for payment of any charges resulting from the client's failure to show up for the appointment. ( )

04. Exception Policy. Any and all exceptions to the upper limits established by section 300.01 of these rules will be reviewed on an individual case basis, and require approval by the rehabilitation services chief of the *Commission*. ( )

~~301. 309. (RESERVED).~~

~~310. AVAILABILITY OF PERSONNEL TRAINED IN CLIENT NATIVE LANGUAGE OR MODE OF COMMUNICATION.~~
~~In cases where it is necessary to provide for interpretation of any mode of communication, the Commission for the Blind and Visually Impaired will seek such services at no cost when available or at cost when necessary.~~ *~~(1-5-87)~~*

~~311. 314. (RESERVED).~~

~~315. BUSINESS ENTERPRISE PROGRAM AND USE OF SECTION 110 DOLLARS IN RANDOLPH SHEPPARD PROGRAM.~~
~~All clients of the Commission for the Blind and Visually Impaired eligible for the Randolph Sheppard Program will be referred to the vocational rehabilitation program for consideration of vocational rehabilitation services.~~ *~~(1-5-87)~~*

~~316. 319. (RESERVED).~~

~~320. PROVISION OF SERVICES TO CERTAIN DISABLED CIVIL SERVICE EMPLOYEES.~~
~~The State Plan will assure that vocational rehabilitation services are available to civil employees of the U.S. government who are disabled in the line of duty under the same terms and conditions~~

~~*applied to other individuals.* *(1-5-87)*~~

~~***321. – 324. (RESERVED).***~~

~~***325. APPROPRIATE COMMUNICATION MEDIA.***~~
~~*The Commission for the Blind and Visually Impaired will provide recorded material for the blind and those individuals with disabilities which make it impossible for them to use printed materials. Certification of the disabling condition will be a part of the application for these services.* *(1-5-87)*~~

~~***326. – 329. (RESERVED).***~~

~~***330. REVIEW OF CASES RECEIVING EXTENDED EVALUATION SERVICES, AND REEVALUATION OF CLIENTS CLOSED STATUS 26 IN SHELTERED WORKSHOPS.***~~
~~*Cases receiving extended evaluation services will be periodically reviewed to determine if the individual is capable of competitive employment. Cases closed Status 26 in sheltered workshops will be reevaluated on an annual basis.* *(1-5-87)*~~

~~***331. – 334. (RESERVED).***~~

~~***335. ADMINISTRATIVE REVIEW – CLIENT SERVICES EVALUATION.***~~
~~*Each office of the Commission for the Blind and Visually Impaired will undergo an administrative review yearly.* *(1-5-87)*~~

~~***336. – 339. (RESERVED).***~~

~~***340. INFORMATION AND REFERRAL SYSTEMS.***~~
~~*The Commission for the Blind and Visually Impaired will develop cooperative agreements with other service providers whereby information regarding the disabled population each agency serves is shared within the limitations of federal rules and regulations, and where appropriate, referrals to other agencies will be made to the benefit of the disabled individual being served.* *(1-5-87)*~~

~~***341. – 344. (RESERVED).***~~

~~***345. NONDISCRIMINATION.***~~
~~*The Commission for the Blind and Visually Impaired will not discriminate against any individual with regard to sex, race, age, creed, color, physical or mental handicap, sexual orientation, or national origin.* *(1-5-87)*~~

3~~46~~01. -- 354. (RESERVED).

355. ~~*ADMINISTRATIVE REVIEW*~~ CLIENT APPEALS.
~~*All applicants will be informed of their right to request a hearing or review as outlined in the Code of Federal Regulations, 34 CFR 361.48. If the client feels there is no resolution, they may request a review from the Secretary of the U.S. Department of Education.* *(1-5-87)*~~

01. Informal Dispute Resolution. Within fifteen (15) calendar days of notification of

the contested action, lack of action or decision, the client may request that an informal dispute resolution be held. The request shall be made in writing to the rehabilitation services chief. The written request should state the reason for the review. ( )

a. The rehabilitation services chief shall inform the client in writing as to the time, place, and date of the informal dispute resolution. The client may choose to represent himself or may have a representative(s) speak on his behalf. ( )

b. The rehabilitation services chief will make a decision regarding the specifics of the informal dispute resolution. This decision will be in written form and it will be sent to the client, with a copy in the case file. ( )

02. **Mediation**. The request shall be made in writing to the rehabilitation services chief. A written request shall state the reason for the review. The mediation must take place within sixty (60) days of client's request. ( )

03. **Impartial Due Process Hearing**. An impartial due process hearing can be held without an informal dispute resolution or mediation or if the client is dissatisfied with the result of the informal dispute resolution or mediation. The impartial due process hearing will deal with the issues involved in the original Informal dispute resolution or mediation, if one took place. The request for an Impartial due process hearing shall be made in writing to the administrator of the Commission within fifteen (15) calendar days of the rehabilitation services chief's decision from the informal dispute resolution or the mediation proceedings. The hearing by an impartial hearing officer must be held within sixty (60) days of a request by the client unless both parties agree to a specified delay. ( )

~~***356. – 359. (RESERVED).***~~

~~***360. CLIENT ASSISTANCE PROJECT.***~~
~~*The Commission for the Blind and Visually Impaired will work cooperatively with coordinators of the Client Assistance Project.* *(1-5-87)*~~

~~***361. – 364. (RESERVED).***~~

~~***365. UTILIZATION OF REHABILITATION FACILITIES.***~~
~~*The Commission for the Blind and Visually Impaired will utilize rehabilitation facilities at such times when this is an appropriate plan which will benefit the client.* *(1-5-87)*~~

~~***366. – 369. (RESERVED).***~~

~~***370. PROVISION OF SERVICES TO GROUPS.***~~
~~*Services to groups may be provided to organizations serving the blind of Idaho only with the approval of the Board of the Commission for the Blind and Visually Impaired, and only in the event funds are available to provide such services.* *(1-5-87)*~~

~~***371. – 374. (RESERVED).***~~

~~***375. BARRIER FREE FACILITIES USED BY SERVICE PROVIDERS.***~~

~~*The Commission for the Blind and Visually Impaired shall work with all facilities and service providers to ensure equal access.* *(1-5-87)*~~

~~***376. -- 379. (RESERVED).***~~

~~***380. DEVELOPMENT OF SUBGRANTS AND CONTRACTS.***~~
~~*The Commission for the Blind and Visually Impaired will follow standards of the Division of Purchasing for requests for proposals in the development of subgrants and contracts.* *(1-5-87)*~~

~~***381. -- 384. (RESERVED).***~~

~~***385. RESPONDING TO FEDERAL REPORTS.***~~
~~*The Commission for the Blind and Visually Impaired will comply with federal requirements regarding federal statistical and financial reporting organizations.* *(1-5-87)*~~

~~***386. -- 389. (RESERVED).***~~

~~***390. RETENTION OF RECORDS.***~~
~~*Client files, and financial and statistical records of the Commission for the Blind and Visually Impaired will be kept for three (3) fiscal years once they become inactive.* *(1-5-87)*~~

~~***391. -- 394. (RESERVED).***~~

~~***395. PUBLIC INPUT TO THE POLICY DEVELOPMENT OF THE COMMISSION.***~~
~~*The Commission for the Blind and Visually Impaired will illicit public input for development of agency policy, rules and regulations.* *(1-5-87)*~~

3~~9~~5. -- 999. (RESERVED).

IDAPA 15 - OFFICE OF THE GOVERNOR

COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.03 - RULES GOVERNING THE INDEPENDENT LIVING PROGRAM

DOCKET NO. 15-0203-0701 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 67-5407(e) and 67-5408, 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.

Various Sections and Subsections have been amended replacing the acronym "ICBVI" with the word "Commission."

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 October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 319 through 322.

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 pending rule, contact Trina Ayres, Management Assistant, at (208) 639-8369.

DATED this 1st day of November, 2007.

Trina Ayres, Management Assistant
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
P. O. Box 83720, Boise, Idaho 83720-0012
(208) 639-8369 phone / (208) 334-2963 fax

COMMISSION FOR THE BLIND & VISUALLY IMPAIRED ***Docket No. 15-0203-0701***
Rules Governing the Independent Living Program ***PENDING RULE***

THE FOLLOWING NOTICE 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 67-5407(e) and 67-5408, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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

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

The proposed changes are needed to promulgate a new chapter of rules governing the *Commission*'s provision of rehabilitation services relating to its federally-mandated Independent Living Program, as provided by Section 67-5408, Idaho Code, and in accordance with applicable sections of the Rehabilitation Act of 1973, its 1998 amendments, and applicable federal regulations. The *Commission*'s 2007 Independent Living Manual includes procedural and practice requirements governing provision of its Independent Living Program to its clients. The *Commission* desires to promulgate a new chapter of administrative rules in the Idaho Administrative Code at IDAPA 15.02.03 setting forth those procedural and practice provisions contained in its 2007 Independent Living Manual that should be IDAPA rules governing its provision of its Independent Living Program. *Commission* also seeks to incorporate by reference into this new chapter applicable federal laws and regulations governing its Independent Living Program.

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 prior to the publication of the proposed rule because the proposed rule allows the provision of benefits to the identifiable interested parties.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Trina Ayres, Management Assistant, at (208) 639-8369.

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 24, 2007.

DATED this 28th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 15
TITLE 02
CHAPTER 03

COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.03 - RULES GOVERNING THE INDEPENDENT LIVING PROGRAM

000. LEGAL AUTHORITY.
This chapter is adopted in accordance with Sections 67-5407(e) and 67-5408, Idaho Code. (____)

001. TITLE AND SCOPE.

01. Title. These rules shall be cited in full as IDAPA 15.02.03, "Rules Governing the Independent Living Program." (____)

02. Scope. These rules include, but are not limited to, the procedure and practice requirements governing the provision of services under the Independent Living Program. (____)

002. WRITTEN INTERPRETATIONS.
The Commission may have written statements that pertain to the interpretation of the rules of this chapter. Such interpretations, if any, are available for public inspection and copying at the offices of the Idaho Commission for the Blind and Visually Impaired. (____)

003. ADMINISTRATIVE APPEALS.
Administrative appeals shall be governed by the Administrative Procedures Act, Title 67, Chapter 52, Idaho Code. (____)

004. INCORPORATION BY REFERENCE.
The following federal laws and regulations are incorporated by reference into the rules of this chapter: (____)

01. 29 U.S.C. Section 701, et. seq., Rehabilitation Act of 1973, as amended in 1998. (____)

02. 34 CFR 364. (____)

005. OFFICE LOCATION - OFFICE HOURS - MAILING ADDRESS - TELEPHONE NUMBER - FACSIMILE NUMBER.

01. Location. The principal place of business of the Idaho Commission for the Blind and Visually Impaired is located at 341 West Washington Street, Boise, Idaho. (____)

02. Office Hours. The office is open from 8 a.m. to 5 p.m., except Saturday, Sunday, and legal holidays. (____)

03. Mailing Address. The mailing address of the office is P. O. Box 83720, Boise, Idaho 83720-0012. (____)

04. Telephone. The telephone number of the office is (208) 334-3220. (____)

05. Facsimile. The facsimile number of the office is (208) 334-2963. (____)

006. PUBLIC RECORDS ACT COMPLIANCE.
Commission records are subject to the provisions of the Idaho Public Records Act, Title 9, Chapter 3, Idaho Code. (____)

***007*. CONFIDENTIALITY.**
All personal information concerning *C*lients is confidential. The information is used only for purposes directly connected to the administration of the *Commission's* Independent Living Program and may not be released without the informed, written consent of the *C*lient, except as otherwise provided by law. *( )*

00*8*. -- 009. (RESERVED).

010. DEFINITIONS.

01. Blind or Visually Impaired. A person whose visual acuity with correcting lenses is not better than 20/200 in the better eye; or a person whose vision in the better eye is restricted to a field which subtends an angle of not greater than twenty (20) degrees; or a person who is functionally blind; or a person who is without any sight. (____)

02. Client. An individual who has applied for, or is determined to be eligible for Independent Living Services. (____)

03. Commission. The Idaho Commission for the Blind and Visually Impaired. (____)

04. Comparable Benefits and Services. Any benefit or service that exists under any other programs that is available to the client. Examples are, but not limited to, Medicaid, Medicare, private health insurance, and medical indigence programs for medication. (____)

05. Functionally Blind. A person with a visual impairment which constitutes or results in a substantial impediment to employment or substantially limits one (1) or more major life activities. (____)

06. Impairment. Any physical, mental, or emotional disability that causes limitations in a functional area such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills. (____)

07. Independent Living Services. Services that reduce the impact of functional limitations on the ability of a client to achieve independence in the family or community. (____)

011. ABBREVIATIONS.

01. CFR. Code of Federal Regulations. ( )

02. ICBVI. Idaho Commission for the Blind and Visually Impaired. (____)

012. – 099. (RESERVED).

100. PROVISION OF SERVICES ON A STATEWIDE BASIS AND APPLICATION.

01. Services. Independent Living Services are offered on a statewide basis to individuals who are blind or visually impaired, subject to eligibility requirements as set forth in Section 110 of these rules. (____)

02. Eligibility Requirements. Eligibility requirements will be applied by the Commission without regard to sex, race, creed, color, physical or mental disability, sexual orientation, or national origin of the individual applying for Services. (____)

03. Application. To apply for Independent Living Services, an individual must meet with an *Commission* rehabilitation teacher and complete an application for Independent Living Services. An individual is considered to have applied for Independent Living Services with the *Commission* when that individual has signed an application for Independent Living Services, including completion and signature of required forms relating to independent living rights and responsibilities and to the release and exchange of information. *(____)*

101. -- 109. (RESERVED).

110. ELIGIBILITY.
Eligibility of a client for Independent Living Services shall be based upon a determination by the Commission that: (____)

01. Blind or Visually Impaired. The client is blind or visually impaired; (____)

02. Ability to Function. The client's blindness or visual impairment substantially limits the client's ability to function in the family or community; (____)

03. Result of Services. Provision of Independent Living Services will improve the client's ability to function, continue functioning, or move toward functioning independently in the family or community; and ( )

04. Residency. The client is a resident of the state of Idaho. ( )

111. -- 149. (RESERVED).

150. INDEPENDENT LIVING PLAN

01. Plan Development. For those clients determined eligible for Independent Living Services, an Independent Living Plan shall be jointly developed by the client and the assigned *Commission* rehabilitation teacher, unless the need for an Independent Living Plan is waived by the client in writing. ( )

02. Plan Contents. If the client chooses to have an Independent Living Plan, it shall include the independent living goals and objectives, Independent Living Services to be provided, including start and end dates, costs, Comparable Benefits and Services involved, client financial participation and any other elements deemed necessary by the *Commission* rehabilitation teacher. ( )

151. -- 199. (RESERVED).

200. CLIENT FINANCIAL PARTICIPATION.
There is no fee assessed for Independent Living Services provided directly to the client by the *Commission* rehabilitation teacher. However, where the provision of Independent Living Services includes the purchase of aids, appliances, assistive technology, computer hardware and software, and other purchased services or devices, the client's ability to pay shall be taken into consideration with the expectation that the client will contribute toward or pay for the required service. *The Commission* shall expend no more than five hundred dollars ($500) per eligible client towards the purchase of aids, appliances, assistive technology, computer hardware and software, and other devices and services. Any exceptions to this rule shall only be granted upon review and approval of the *Commission* independent living coordinator. ( )

201. -- 999. (RESERVED).

IDAPA 15 - OFFICE OF THE GOVERNOR

COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.04 - RULES GOVERNING THE PREVENTION OF BLINDNESS AND SIGHT RESTORATION PROGRAM

DOCKET NO. 15-0204-0701 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 67-5407(d) and (e), 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 text of the proposed rule was published in the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 323 through 326.

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 pending rule, contact Trina Ayres, Management Assistant, at (208) 639-8369.

DATED this 1st day of November, 2007.

Trina Ayres
Management Assistant
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
P. O. Box 83720, Boise, Idaho 83720-0012
(208) 639-8369 phone / (208) 334-2963 fax

COMMISSION FOR THE BLIND & VISUALLY IMPAIRED ***Docket No. 15-0204-0701***
Prevention of Blindness and Sight Restoration Program ***PENDING RULE***

THE FOLLOWING NOTICE 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 67-5407 (d) and (e), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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

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

The proposed rule changes are needed to promulgate a new chapter of rules governing the ICBVI's program for the Prevention of Blindness and Sight Restoration, as mandated by Section 67-5407(d), Idaho Code. The ICBVI's 2007 State Only Prevention of Blindness and Sight Restoration Program Manual includes procedural and practice requirements governing provision of its Prevention of Blindness and Sight Restoration Program ("Program") to its clients. The ICBVI desires to promulgate a new chapter of administrative rules in the Idaho Administrative Code at IDAPA 15.02.04 setting forth those procedural and practice provisions contained in its 2007 State Only Prevention of Blindness and Sight Restoration Program Manual that should be IDAPA rules governing its provision of the Program.

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 prior to the publication of the proposed rule because the proposed rule allows the provision of benefits to the identifiable interested parties.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Trina Ayres, Management Assistant, at (208) 639-8369.

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 24, 2007.

DATED this 28th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 15
TITLE 02
CHAPTER 04

COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.04 – RULES GOVERNING THE PREVENTION OF BLINDNESS AND SIGHT RESTORATION PROGRAM

000. LEGAL AUTHORITY.
This chapter is adopted in accordance with Section 67-5407(d) and (e), Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. These rules shall be cited in full as IDAPA 15.02.04, "Rules Governing the Prevention of Blindness and Sight Restoration Program." ( )

02. Scope. These rules include, but are not limited to, the procedure and practice requirements governing the provision of services under the Prevention of Blindness and Sight Restoration Program. ( )

002. WRITTEN INTERPRETATIONS.
The Commission may have written statements that pertain to the interpretation of the rules of this chapter. Such interpretations, if any, are available for public inspection and copying at the offices of the Idaho Commission for the Blind and Visually Impaired. ( )

003. ADMINISTRATIVE APPEALS.
Administrative appeals shall be governed by the Administrative Procedures Act, Title 67, Chapter 52, Idaho Code. ( )

004. INCORPORATION BY REFERENCE.
There are no documents incorporated by reference into the rules of this chapter. ( )

005. OFFICE LOCATION -- OFFICE HOURS -- MAILING ADDRESS -- TELEPHONE NUMBER -- FACSIMILE NUMBER.

01. Location. The principal place of business of the Idaho Commission for the Blind and Visually Impaired is located at 341 West Washington Street, Boise, Idaho. ( )

02. Office Hours. The office is open from 8 a.m. to 5 p.m., except Saturday, Sunday, and legal holidays. ( )

03. Mailing Address. The mailing address of the office is P. O. Box 83720, Boise, Idaho 83720-0012. ( )

04. Telephone. The telephone number of the office is (208) 334-3220. ( )

05. Facsimile. The facsimile number of the office is (208) 334-2963. ( )

007. PUBLIC RECORDS ACT COMPLIANCE.
Commission records are subject to the provisions of the Idaho Public Records Act, Title 9, Chapter 3, Idaho Code. ( )

0*08*. CONFIDENTIALITY.
All personal information concerning *C*lients is confidential. The information is used only for purposes directly connected to the administration of the Commission's Blind Prevention and Sight Restoration Program and may not be released without the informed, written consent of the *C*lient, except as otherwise provided by law. *( )*

009. (RESERVED).

010. DEFINITIONS.

01. Blind or Visually Impaired. A person whose visual acuity with correcting lenses is not better than 20/200 in the better eye; or a person whose vision in the better eye is restricted to a field which subtends an angle of not greater than twenty (20) degrees; or a person who is functionally blind; or a person who is without any sight. ( )

02. Client. An individual who has applied for, or is determined to be eligible for, Prevention of Blindness or Sight Restoration Services. ( )

03. Commission. The Idaho Commission for the Blind and Visually Impaired. ( )

04. Comparable Benefits or Services. Any benefit or service that exists under any other programs that is available to the client. Examples are, but not limited to, Medicaid, Medicare, private health insurance, and medical indigence programs for medication. ( )

05. Functionally Blind. A person with a visual impairment which constitutes or results in a substantial impediment to employment or substantially limits one (1) or more major life activities. ( )

06. Immediate Danger of Blindness. The status of an individual or client who is in danger of becoming blind or visually impaired within two (2) years. ( )

07. Prevention of Blindness and Sight Restoration Services or Services. *T*reatment or surgery to prevent blindness or restore vision to *C*lients without financial resources to procure such Services for themselves. *( )*

011. -- 099. (RESERVED).

100. PROVISION OF SERVICES ON A STATEWIDE BASIS.
Prevention of Blindness and Sight Restoration Services are offered on a statewide basis to individuals who are *B*lind *or V*isually *I*mpaired or who are in immediate danger of *B*lindness, subject to eligibility and available funding. To apply, individuals must meet with a vocational rehabilitation assistant *from* the Commission to complete and sign an application. *( )*

101. -- 109. (RESERVED).

110. ELIGIBILITY.
Eligibility of a client for Prevention of Blindness and Sight Restoration Services shall be based upon a determination by the Commission that a client is blind or visually impaired, functionally blind, or in immediate danger of blindness and that the client is without financial resources to procure Services for himself. Clients must also meet residency requirements as set forth in Subsection 110.02 of these rules. ( )

01. Demonstration of Financial Need. Only clients without financial resources to procure Services for themselves are eligible for Prevention of Blindness and Sight Restoration Services. Clients shall undergo a financial needs assessment with Commission staff to determine whether financial eligibility requirements are met. ( )

02. Residency Requirements. In order to be eligible for Prevention of Blindness and Sight Restoration Services, a client must demonstrate the following residency requirements: ( )

a. If client is not a United States citizen, client shall provide proof of his legal presence as a registered alien in the United States. ( )

b. Residence in the state of Idaho for a minimum of six (6) months; and ( )

c. Presence in the state of Idaho at the time of provision of Prevention of Blindness and Sight Restoration Services. ( )

112 -- 199. (RESERVED).

200. PAYMENT FOR NECESSARY EXPENSES.
The Commission's payment of necessary expenses associated with provision of Prevention of Blindness and Sight Restoration Services to eligible clients is subject to availability of funds during any single state fiscal year. In the event available funds for Prevention of Blindness and Sight Restoration Services are exhausted prior to the end of any single state fiscal year, eligible

clients are placed on a waiting list until such time as funding is available to resume Prevention of Blindness and Sight Restoration Services. ( )

01. Upper Limits. Subject to Subsection 200.03 of these rules, the Commission shall pay no more than five thousand dollars ($5,000) per eligible client for necessary expenses incurred for Prevention of Blindness and Sight Restoration Services during each eligible client's lifetime participation in the Blind Prevention and Sight Restoration Program. ( )

02. Comparable Benefits and Services. Eligible clients shall apply for and secure any comparable benefits and services which shall be applied towards payment of necessary expenses incurred for Prevention of Blindness and Sight Restoration Services before any expenditure of Commission funds. ( )

03. Exceptions. Any exceptions to the individual lifetime limit per eligible *C*lient set forth in Subsection 200.01 of these rules shall only be granted upon approval of the *Commission* rehabilitation services chief. *( )*

2*01*. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

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

DOCKET NO. 16-0202-0701 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is February 1, 2007. This pending rule has been adopted by the agency and is now pending review by the 2008 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 56-1013A and 56-1017, Idaho Code, and House Bill 858 (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 public hearings, written comments submitted during the comment period, and comments or corrections from the members of the Emergency Medical Services (EMS) Physician Commission. The following are specific changes made to the pending and temporary rules:

Section 100 - Deleted a redundant phrase, added a phrase clarifying that the hospital or medical clinic supervising physician may approve additional training of certified EMS personnel, and clarified that certified EMS personnel must not provide "out-of-hospital care" that exceeds the scope of practice established by the Commission.

Section 300 - Added further clarification as to how an EMS medical director, hospital supervising physician, or medical clinic supervising physician may credential certified EMS personnel under his supervision with a limited scope of practice.

Section 400 - Corrected the citation to IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," and clarified the reference to advanced directives of patients and physicians with the addition of specific reference to "Physician Orders for Scope Treatment (POST) or other valid Do Not Resuscitate (DNR) orders."

Section 500 - Added clarification that the hospital or medical clinic must maintain a current written description of acts and duties authorized by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel and that they must submit the descriptions upon request of the Commission or the EMS Bureau.

Also, corrected the citation to IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," and added the clarification that the Medical Supervision Plan must be submitted, upon request, to the EMS Physician Commission or the EMS Bureau.

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 EMS Physician Commission 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 3, 2007, Idaho Administrative Bulletin, Vol. 07-1, pages 57 through 68.

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 as result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact Dia Gainor at (208) 334-4000.

DATED this 20th day of September, 2007.

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@dhw.idaho.gov e-mail

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is February 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 rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-1013A and 56-1017, Idaho Code, and House Bill 858 (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 Friday, April 13, 2007.

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:

To best protect the public's health and safety, the newly-established EMS Physician Commission is proposing a new chapter of rules to regulate the scope of practice and medical supervision standards for EMS personnel in Idaho.

Currently, there are no scope of practice rules in effect since the rulemaking authority for the previously-existing EMS scope of practice rules was transferred from the Board of Medicine to the EMS Physician Commission by the 2006 Legislature. The Legislature gave the EMS Physician Commission this authority because EMS scope of practice issues have become increasingly complex and require the specialized knowledge and experience of physicians who are specialists in emergency medical care.

Since the old EMS scope of practice rules are no longer in effect, the EMS Physician Commission is establishing new rules to replace them and to comply with the current statutory requirements found in Section 56-1017, Idaho Code.

This new chapter of rules defines the standard operating procedures and practices that can be performed by those certified by the Department as EMS providers. The rules also define the required level of physician supervision for persons certified as EMS providers.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate since it is necessary for the protection of the public health, safety, or welfare.

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 impact to the State General Fund as result of this rulemaking.

Revenue from the dedicated "Emergency Medical Services Fund" established in Section 56-1018, Idaho Code, will be utilized to conduct pilot programs and to produce policy and guideline documents related to this rulemaking. These costs are estimated at $7,500. The EMS Physician Commission is funded entirely by receipts in accordance with Section 56-1013A(6), Idaho Code, that will fund the costs of rulemaking. Idaho licensed EMS agencies may continue to incur costs associated with complying with the rules promulgated by the EMS Physician Commission; these costs are commensurate with the historical costs associated with rulemaking by the Board of Medicine.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the new chapter was developed by the newly-authorized Emergency Medical Services (EMS) Physician Commission. The EMS Physician Commission is itself a representative body of emergency medicine physicians and citizens with EMS experience from across the state. In developing the new chapter, the Commission had access to public input that was provided when the rule was going to be rewritten under the Idaho Board of Medicine.

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

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 April 27, 2007.

DATED this 15th day of November, 2006.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16
TITLE 02
CHAPTER 02

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

000. LEGAL AUTHORITY.
Under Sections 56-1013A and 56-1017, Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission is authorized to promulgate these rules for the purpose of establishing standards for scope of practice and medical supervision for certified personnel, ambulance services, and non-transport agencies licensed by the Department of Health and Welfare. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ( )

02. Scope. The scope of these rules is to define the allowable scope of practice, acts, and duties that can be performed by persons certified as emergency medical services personnel by the Department of Health and Welfare Emergency Medical Services (EMS) Bureau and to define the required level of supervision by a physician. ( )

002. WRITTEN INTERPRETATIONS.

There are no written interpretations of these rules. ( )

003. ADMINISTRATIVE APPEALS AND INVESTIGATIONS.

01. Administrative Appeals. Provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," govern administrative appeals. ( )

02. Physician Complaint Investigations. The provisions of IDAPA 22.01.04, "Rules Relating to Complaint Investigation," govern investigation of complaints regarding physicians. ( )

03. EMS Personnel and EMS Agency Complaint Investigations. The provisions of IDAPA 16.02.03, "Rules Governing Emergency Medical Services," govern investigation of complaints regarding certified EMS personnel and EMS Agencies. ( )

004. INCORPORATION BY REFERENCE.
The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2007-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained from the EMS Bureau located at 590 W. Washington Street, Boise, Idaho, 83702, whose mailing address is P.O. 83720, Boise, Idaho 83720-0036. ( )

005. OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS - TELEPHONE -- WEBSITE.
The Idaho Emergency Medical Services (EMS) Physician Commission is administered by the EMS Bureau central office located in Boise Idaho. ( )

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

02. Mailing Address. ( )

a. The mailing address for the business office is: EMS Bureau, P.O. Box 83720, Boise, Idaho 83720-0036. ( )

b. The mailing address for the Idaho EMS Physician Commission, unless otherwise indicated, is: Idaho EMS Physician Commission, P.O. Box 83720, Boise, Idaho 83720-0036. ( )

03. Street Address. ( )

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

b. The central office of the Idaho EMS Bureau is located at 590 West Washington Street, Boise, Idaho 83702. ( )

04. Telephone and Facsimile. ( )

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

b. The telephone number for the Idaho EMS Physician Commission and the Idaho EMS Bureau is (208) 334-4000. ( )

c. The fax number for the Idaho EMS Physician Commission and the Idaho EMS Bureau is (208) 334-4015. ( )

05. Internet Website. ( )

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

b. The Idaho EMS Physician Commission and the Idaho EMS Bureau website is found at: http://www.idahoems.org. ( )

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. ( )

03. EMS Complaints. The provisions of IDAPA 16.02.03, "Rules Governing Emergency Medical Services," govern the confidentiality of the investigation of complaints regarding certified EMS personnel. ( )

007. -- 009. (RESERVED).

010. DEFINITIONS.
In addition to the applicable definitions in Section 56-1012, Idaho Code, and IDAPA 16.02.03, "Rules Governing Emergency Medical Services," the following terms are used in this chapter as defined below: ( )

01. Certification. A license issued by the EMS Bureau to an individual for a specified period of time indicating that minimum standards corresponding to one (1) of several levels of EMS proficiency have been met. ( )

02. Certified EMS Personnel. Individuals who possess a valid certification issued by the EMS Bureau. ( )

03. Credentialed EMS Personnel. Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

04. Credentialing. The local process by which certified EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice. ( )

05. Designated Clinician. A licensed Physician Assistant (PA) or Nurse Practitioner designated by the EMS medical director, hospital supervising physician, or medical clinic supervising physician who is responsible for direct (on-line) medical supervision of certified EMS personnel in the temporary absence of the EMS medical director. ( )

06. Direct (On-Line) Supervision. Contemporaneous instructions and directives about a specific patient encounter provided by a physician or designated clinician to certified EMS personnel who are providing medical care. ( )

07. Emergency Medical Services (EMS). The services utilized in responding to a perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury. ( )

08. Emergency Medical Services (EMS) Bureau. The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. ( )

09. Emergency Medical Services (EMS) Physician Commission. The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code, hereafter referred to as "the Commission." ( )

10. EMS Agency. An organization licensed by the EMS Bureau to provide emergency medical services in Idaho. ( )

11. EMS Medical Director. A physician who supervises the medical activities of certified personnel affiliated with an EMS agency. ( )

12. Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code. ( )

13. Hospital Supervising Physician. A physician who supervises the medical activities of certified EMS personnel while employed or utilized for delivery of services in a hospital. ( )

14. Indirect (Off-Line) Supervision. The medical supervision, provided by a physician, to certified EMS personnel who are providing medical care including EMS system design, education, quality management, patient care guidelines, medical policies, and compliance. ( )

15. Medical Clinic. A place devoted primarily to the maintenance and operation of facilities for outpatient medical, surgical, and emergency care of acute and chronic conditions or

injury. ( )

16. Medical Clinic Supervising Physician. A physician who supervises the medical activities of certified EMS personnel while employed or utilized for delivery of services in a medical clinic. ( )

17. Medical Supervision. The advice and direction provided by a physician, or under the direction of a physician, to certified EMS personnel who are providing medical care, including direct and indirect supervision. ( )

18. Medical Supervision Plan. The written document describing the provisions for medical supervision of certified EMS personnel. ( )

19. Nurse Practitioner. An Advanced Practice Professional Nurse, licensed in the category of Nurse Practitioner, as defined in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ( )

20. Out-of-hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of emergency medical services may take place. ( )

21. Physician. A person who holds a current active license issued by the Board of Medicine to practice medicine and surgery or osteopathic medicine or surgery in Idaho and is in good standing with no restriction upon, or actions taken against, his license. ( )

22. Physician Assistant. A person who meets all the applicable requirements to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." ( )

011. -- 094. (RESERVED).

095. GENERAL PROVISIONS.

01. Practice of Medicine. This chapter does not authorize the practice of medicine or any of its branches by a person not licensed to do so by the Board of Medicine. ( )

02. Patient Consent. The provision or refusal of consent for individuals receiving emergency medical services is governed by Title 39, Chapter 43, Idaho Code. ( )

03. System Consistency. All EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians must collaborate to ensure EMS agencies and certified EMS personnel have protocols, policies, standards of care, and procedures that are consistent and compatible with one another. ( )

096. -- 099. (RESERVED).

100. GENERAL DUTIES OF EMS PERSONNEL.

01. General Duties. General duties of EMS personnel include the following:

( )

a. Certified EMS personnel must possess valid certification issued by the EMS Bureau equivalent to or higher than the scope of practice authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

b. Certified EMS personnel must only provide patient care for which they have been trained, based on curricula or specialized training approved according to IDAPA 16.02.03, "Rules Governing Emergency Medical Services," *or additional training approved by the hospital or medical clinic supervising physician.* *( )*

c. Certified EMS personnel must not perform a task or tasks within their scope of practice that have been specifically prohibited by their EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

d. Certified EMS personnel that possess a valid credential issued by the EMS medical director, hospital supervising physician, or medical clinic supervising physician are authorized to provide services when representing an Idaho EMS agency, hospital, or medical clinic and under any one (1) of the following conditions: ( )

i. When part of a documented, planned deployment of personnel resources approved by the EMS medical director, hospital supervising physician, or medical clinic supervising physician; or ( )

ii. When, in a manner approved by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, administering first aid or emergency medical attention in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration; or ( )

iii. When participating in a training program approved by the EMS Bureau, the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

02. Scope of Practice. ( )

a. The Commission maintains an "EMS Physician Commission Standards Manual" that: ( )

i. Establishes the scope of practice of certified EMS personnel; and ( )

ii. Specifies the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS certification. ( )

b. The Commission will consider the United States Department of Transportation's National EMS Scope of Practice Model when preparing or revising the standards manual described in Subsection 100.02.a. of this rule; ( )

c. The scope of practice established by the EMS Physician Commission determines

the objectives of applicable curricula and specialized education of certified EMS personnel. ( )

d. The scope of practice does not define a standard of care, nor does it define what should be done in a given situation; ( )

e. Certified EMS personnel must not provide *out-of-hospital patient care* that exceeds the scope of practice established by the Commission; *( )*

f. Certified EMS personnel must be credentialed by the EMS medical director, hospital supervising physician, or medical clinic supervising physician to be authorized for their scope of practice; ( )

g. The credentialing of certified EMS personnel affiliated with an EMS agency, in accordance with IDAPA 16.02.03, "Rules Governing Emergency Medical Services," must not exceed the licensure level of that EMS agency; and ( )

h. The patient care provided by certified EMS personnel must conform to the Medical Supervision Plan as authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

101. -- 199. (RESERVED).

200. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN QUALIFICATIONS.
The EMS Medical Director, Hospital Supervising Physician, and Medical Clinic Supervising Physician must: ( )

01. Accept Responsibility. Accept responsibility for the medical direction and medical supervision of the activities provided by certified EMS personnel. ( )

02. Maintain Knowledge of EMS Systems. Obtain and maintain knowledge of the contemporary design and operation of EMS systems. ( )

03. Maintain Knowledge of Idaho EMS. Obtain and maintain knowledge of Idaho EMS laws, regulations, and standards manuals. ( )

201. -- 299. (RESERVED).

300. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN RESPONSIBILITIES AND AUTHORITY.

01. Documentation of Written Agreement. The EMS medical director must document a written agreement with the EMS agency to supervise certified EMS personnel and provide such documentation to the EMS Bureau annually or upon request. ( )

02. Approval for EMS Personnel to Function. ( )

a. The explicit approval of the EMS medical director, hospital supervising physician, or medical clinic supervising physician is required for certified EMS personnel under his supervision to provide medical care. ( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician may credential certified EMS personnel under his supervision with a limited scope of practice relative to that allowed by the EMS Physician Commission, *or with a limited scope of practice corresponding to a lower level of EMS certification.* *( )*

03. Restriction or Withdrawal of Approval for EMS Personnel to Function. ( )

a. The EMS medical director, hospital supervising physician, or medical clinic supervising physician can restrict the scope of practice of certified EMS personnel under his supervision when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the Idaho EMS Bureau. ( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician can withdraw approval of certified EMS personnel to provide services, under his supervision, when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the EMS Bureau. ( )

c. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must report in writing such restriction or withdrawal of approval within fifteen (15) days of the action to the EMS Bureau in accordance with Section 39-1393, Idaho Code. ( )

04. Review Qualifications of EMS Personnel. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual. ( )

05. Document EMS Personnel Proficiencies. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document that the capabilities of certified EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment. ( )

06. Develop and Implement a Performance Assessment and Improvement Program. The EMS medical director must develop and implement a program for continuous assessment and improvement of services provided by certified EMS personnel under their supervision. ( )

07. Review and Update Procedures. The EMS medical director must review and update protocols, policies, and procedures at least every two (2) years. ( )

08. Develop and Implement Plan for Medical Supervision. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must develop, implement and oversee a plan for supervision of certified EMS personnel as described in Subsection 400.06 of these rules. ( )

09. Access to Records. The EMS medical director must have access to all relevant agency, hospital, or medical clinic records as permitted or required by statute to ensure responsible medical supervision of certified EMS personnel. ( )

301. -- 399. (RESERVED).

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

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

02. Designation of EMS Medical Director. The EMS agency must designate a physician for the medical supervision of certified EMS personnel affiliated with the EMS agency. ( )

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

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

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

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

c. The physician supervising the PA, as defined in IDAPA 22.01.*03*, "Rules *for the Licensure of Physician Assistants*," authorizes the PA to provide direct (on-line) supervision; and *( )*

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

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

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

06. Medical Supervision Plan. The medical supervision of certified EMS personnel must be provided in accordance with a documented medical supervision plan that includes direct, indirect, on-scene, educational, and proficiency standards components. The EMS medical director is responsible for developing, implementing, and overseeing the medical supervision plan that must consist of the following elements: ( )

a. Certified EMS personnel credentialing that includes all of the following: ( )

i. EMS Bureau certification; ( )

ii. Affiliation to the EMS agency; ( )

iii. An EMS agency orientation as prescribed by the EMS agency that includes:( )

(1) EMS agency policies; ( )

(2) EMS agency procedures; ( )

(3) Medical treatment protocols; ( )

(4) Radio communications procedures; ( )

(5) Hospital/facility destination policies; ( )

(6) Other unique system features; and ( )

iv. Successful completion of an EMS agency evaluation. ( )

b. Indirect (off-line) supervision that includes all of the following: ( )

i. Written standing orders and treatment protocols including direct (online) supervision criteria; ( )

ii. Initial and continuing education in addition to those required by the EMS Bureau; ( )

iii. Methods of assessment and improvement; ( )

iv. Periodic assessment of psychomotor skill proficiency; ( )

v. Provisions for medical supervision of and defining the patient care provided by certified EMS personnel who are present for a multiple or mass causality incident, disaster response, or other significant event involving response of certified EMS personnel; ( )

vi. Defining the response when certified EMS personnel discover a need for EMS while not on duty; ( )

vii. The credentialing of certified EMS personnel for emergency response; ( )

viii. The appropriate level of emergency response based upon dispatch information provided by the designated Public Safety Answering Point(s); ( )

ix. Triage, treatment, and transport guidelines; ( )

x. Scene management for multiple EMS agencies anticipated to be on scene concurrently; ( )

xi. Criteria for determination of patient destination; ( )

xii. Criteria for utilization of air medical services in accordance with IDAPA 16.02.03, "Rules Governing Emergency Medical Services," Section 415; ( )

xiii. Policies and protocols for patient refusal, "treat and release," *Physician Orders for Scope of Treatment (POST) or other valid Do Not Resuscitate (DNR) orders, and* determination of death and other predictable patient non-transport scenarios; *( )*

xiv. Criteria for cancellation or modification of EMS response; ( )

xv. Equipment authorized for patient care; ( )

xvi. Medical communications guidelines; and ( )

xvii. Methods and elements of documentation of services provided by certified EMS personnel. ( )

c. Direct (on-line) supervision: ( )

i. Is accomplished by concurrent communication with the EMS medical director, other physicians designated by the EMS medical director, or designated clinicians who must be available twenty-four (24) hours a day seven (7) days a week. ( )

ii. The EMS medical director will develop and implement procedures in the event of on-scene supervision by: ( )

(1) The EMS medical director or other physician(s) designated by the EMS medical director; ( )

(2) A physician with a pre-existing relationship with the patient; and ( )

(3) A physician with no pre-existing relationship with the patient who is present for the duration of treatment on scene or transportation. ( )

iii. Direct supervision of certified EMS personnel by other persons is prohibited except in the manner described in the medical supervision plan. ( )

d. The EMS medical director in collaboration with the course medical director or course coordinator, will define standards of supervision and training for students of state-approved training programs placed for clinical practice and training. ( )

07. Out-of-Hospital Medical Supervision Plan Filed with EMS Bureau. The agency EMS medical director must file the medical supervision plan, including identification of the EMS medical director and any designated clinicians to the EMS Bureau in a form described in the standards manual. ( )

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

b. The EMS Bureau must provide the Commission with the medical supervision plans annually and upon request. ( )

c. The EMS Bureau must provide the Commission with the identification of EMS Medical directors and designated clinicians annually and upon request. ( )

401. -- 499. (RESERVED).

500. PHYSICIAN SUPERVISION IN HOSPITALS AND MEDICAL CLINICS.

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

02. Level of Certification Identification. The certified EMS personnel employed or utilized for delivery of services within a hospital or medical clinic, when on duty, must at all times visibly display identification specifying their level of EMS certification. ( )

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

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

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

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

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

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

b. The physician supervising the PA, as defined in IDAPA 22.01.*03*, "Rules *for the Licensure of Physician Assistants*," authorizes the PA to provide supervision; and *( )*

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

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

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

09. Medical Supervision Plan. The medical supervision of certified EMS personnel must be provided in accordance with a documented medical supervision plan. The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the medical supervision plan*, and must submit the plan(s) upon request of the Commission or the EMS Bureau*. *( )*

501. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.08 - VITAL STATISTICS RULES

DOCKET NO. 16-0208-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 39-242 and 39-5403, Idaho Code, and Senate Bill 1069 (2007) which modified Sections 39-260 and 39-268, 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.

Based on public comment received, the proposed rule is being amended to clarify the intent of Subsection 850.01.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only the section that has changes that differ from the proposed text is printed in this bulletin. The complete text of the proposed rule was published in the Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 365 through 367.

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 to the state general fund related to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact James Aydelotte at (208) 334-4969.

DATED this 25th day of October, 2007.

Sherri Kovach, Program Supervisor
DHW – Administrative Procedures Section
450 West State Street - 10th Floor
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kovachs@dhw.idaho.gov e-mail

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0208-0701***
Vital Statistics Rules ***PENDING RULE***

THE FOLLOWING NOTICE 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 and 39-5403, Idaho Code, and Senate Bill 1069 (2007) which modified Sections 39-260 and 39-268, 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 17, 2007.

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:

In many areas of Idaho, physicians are not always available to sign death and stillbirth certificates. To respond to this need, the Department submitted a change to statute in the 2007 legislative session to add advanced practice professional nurses and physician assistants to the list of those legally authorized to sign death and stillbirth certificates and authorize the final disposition and removal of a dead body or stillborn fetus. This change to statute was passed as Senate Bill 1069 (2007) which modified Sections 39-260 and 39-268, Idaho Code.

This rulemaking amends the vital statistics rules to align them with the changes in statute made under SB 1069. In addition, a reference to the official form required for updating a death certificate was added to clarify the requirement.

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 is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking is being done simply to align the rules with SB 1069 passed during the 2007 legislative session.

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 24, 2007.

DATED this 20th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

450. REGISTRATION OF DEATHS AND STILLBIRTHS.

01. Acceptance of Incomplete Death Certificate. If all the information necessary to complete a death certificate is not available within ~~*the time prescribed for filing the certificate*~~ five (5) days after the date the death occurred, the person in charge of interment or removal of the body from the district ~~*shall*~~ in which the death occurred must file the certificate as prescribed by the State Registrar with all information that is available, provided that the medical certification of the cause of death has been signed by the ~~*physician or coroner*~~ person responsible for such certification. If the cause of death is unknown or undetermined, the cause of death ~~*shall*~~ must be shown as unknown or undetermined on the certificate. The ~~*physician or coroner*~~ person responsible for the medical certification ~~*shall*~~ of the cause of death must also sign the authorization for final disposition of the body. If the body is to be cremated, the coroner must also give additional authorization. ~~*(12-26-83)*~~(____)

a. A supplemental report providing the cause of death information missing from the original certificate ~~*shall*~~ must be filed by the ~~*certifying physician or coroner*~~ person responsible for medical certification of the cause of death with the State Registrar within fifteen (15) days of the filing of the death certificate on a form provided or approved by the State Registrar. ~~*(12-26-83)*~~(____)

b. A supplemental report providing all other information missing from the original certificate ~~*shall*~~ must be filed with the State Registrar by the person responsible for filing the certificate within thirty (30) days of the date the death occurred or as otherwise authorized by the State Registrar on a form provided or approved by the State Registrar. ~~*(12-26-83)*~~(____)

c. The State Registrar will make the information on the supplemental report(s) ~~*shall be made*~~ a part of the existing death certificate and will file the supplemental report(s) ~~*shall be filed*~~ with the death certificate. The State Registrar will also mark the death certificate ~~*shall be marked*~~ to show that supplemental information was added. ~~*(12-26-83)*~~(____)

02. Signatures Required on Death Certificates. (12-26-83)

a. The mortician, or person acting as such, ~~*shall*~~ must sign the death certificate. No stamps or other types of facsimile signatures may be used. ~~*(12-26-83)*~~(____)

b. The responsible ~~*physician or coroner*~~ person must sign the medical certification of the cause of death. Failure to do so will invalidate the record as a legal document. No stamps or other types of facsimile signatures may be used. ~~*(12-26-83)*~~(____)

c. The local registrar must sign the certificate. The registrar's signature must be the same as it appears in the notarized certificate of appointment. No stamps or other types of facsimile signatures may be used. (12-26-83)

03. Signatures Required on Stillbirth Certificates. (12-26-83)

a. The mortician's signature must meet the following criteria: (12-26-83)

i. The mortician, or person acting as such, ~~*shall*~~ must sign the certificate. No stamps or other types of facsimile signatures may be used. ~~*(12-26-83)*~~(____)

ii. When a hospital disposes of a stillborn fetus, in accordance with Section 39-268(~~*c*~~3), Idaho Code, the hospital authority ~~*shall*~~ must complete and sign the certificate as mortician. ~~*(12-26-83)*~~(____)

b. The person responsible according to Section 39-260, Idaho Code, for the attendant or medical certification, must sign the certificate. No stamps or other types of facsimile signatures may be used. (12-26-83)

c. The local registrar must sign the certificate. The registrar's signature must be the same as it appears in the notarized certificate of appointment. No stamps or other types of facsimile signatures may be used. (12-26-83)

(BREAK IN CONTINUITY OF SECTIONS)

850. REMOVAL OF DEAD BODY OR FETUS FROM PLACE OF DEATH OR STILLBIRTH.
Before removing a dead body or fetus from the place of death or stillbirth, the funeral director, or person acting as such, ~~*shall obtain assurance from the attending physician or the physician's designate that the death or stillbirth is from natural causes and that the physician or the physician's designate will assume responsibility for certification of the cause of death or stillbirth, and receive from the attending physician or the physician's designate permission to remove the dead body or fetus from the place of death or stillbirth, or shall notify the coroner if the case comes within the jurisdiction of the coroner and obtain authorization to remove the dead body or fetus. In addition, the coroner may authorize removal of the dead body or fetus when death or stillbirth is due to natural causes only when there was no attending physician during the last illness, or there was no physician in attendance at the stillbirth, or when the attending physician or the physician's designate is not available or is physically incapable of providing the assurance or permission.*~~ must, in accordance with Section 39-268, Idaho Code: ~~*(12-26-83)*~~(____)

01. Obtain Assurance That Death Is from Natural Causes. Obtain assurance from

the attending physician, physician assistant, advanced practice professional nurse, *or his designee*, responsible for medical certification of the cause of death *or stillbirth:* *(____)*

a. *T*hat the death or stillbirth is from natural causes*;* and *(____)*

b. *T*hat the attending *physician*, *physician assistant*, *advanced practice professional nurse*, *or his designee*, will assume responsibility for certification of the cause of death or stillbirth; or *(____)*

02. **Notify the Coroner**. Notify the coroner when: (____)

a. The case falls within the jurisdiction of the coroner in accordance with Section 39-260, Idaho Code; or (____)

b. The death or stillbirth is due to natural causes; and (____)

i. There was no attending physician, physician assistant, or advanced practice professional nurse during the last illness; or (____)

ii. There was no physician, physician assistant, or advanced practice professional nurse in attendance at the stillbirth; or (____)

iii. When the attending physician, physician assistant, advanced practice professional nurse, or his designate, is not available or is physically incapable of providing assurance that the death or stillbirth is from natural causes or providing permission to remove the dead body or fetus from the place of death or stillbirth. (____)

03. **Receive Permission to Remove the Dead Body or Fetus**. Receive permission to remove the dead body or fetus from the place of death or stillbirth from: (____)

a. The attending physician, physician assistant, advanced practice professional nurse, or his disignee, if the death is from natural causes and all assurances in Subsection 850.01 of this rule have been met; or (____)

b. The coroner, if the case falls within the jurisdiction of the coroner, in accordance with Section 39-260, Idaho Code, or if the death or stillbirth is due to natural causes and one (1) of the conditions listed in Subsections 850.02.b.i. through 850.02.b.iii. of this rule has been met. (____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.10 - IDAHO REPORTABLE DISEASES

DOCKET NO. 16-0210-0701 (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 2008 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 Sections 39-605, 39-906, 39-1003, 39-1603, 39-4504, 56-1003, and 56-1005, 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 Idaho Reportable Diseases chapter of rules is being repealed because the chapter is hard to navigate and understand for compliance of reporting diseases and conditions. The pending rule is being adopted as proposed. The text of the proposed rule was published in the September 5, 2007, Idaho Administrative Bulletin, Vol. 07-9, page 97.

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.

This rulemaking has no fiscal impact to the state's general fund.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule, contact Kathryn Turner at (208) 334-5870.

DATED this 9th day of October, 2007.

Sherri Kovach, Program Supervisor
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THE FOLLOWING NOTICE PUBLISHED IN 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 39-605, 39-906, 39-1003, 39-1603, 39-4504, 56-1003, and 56-1005, 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 19, 2007.

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 Idaho Reportable Diseases chapter of rules is being repealed because the chapter is hard to navigate and understand for compliance of reporting diseases and conditions. The text of the rewritten chapter is published in this Bulletin under Docket 16-0210-0702.

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.

This rulemaking has no fiscal impact to the state's general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule change is being made in order to reorganize the existing chapter. Public health Districts and other stakeholders have been notified of the repeal of the chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kathryn Turner at (208) 334-5870.

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 26, 2007.

DATED this 25th day of July, 2007.

IDAPA 16.02.10 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.10 - IDAHO REPORTABLE DISEASES

DOCKET NO. 16-0210-0702 (CHAPTER REWRITE)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 39-605, 39-906, 39-1003, 39-1603, 39-4504, 56-1003, and 56-1005, 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 Idaho Reportable Diseases chapter of rules provides for disease surveillance and control and requires specified individuals to report certain diseases and conditions to the Department or Health Districts. These reporting requirements help protect the public from diseases that can be harmful or life-threatening to others if the disease is not reported and contained.

The following revisions are being made to the pending rule: (1) addition of invasive Methicillin-Resistant Staphylococcus aureus (MRSA) as a reportable disease, including control measures for specific manifestations of MRSA infections; (2) addition of definitions for "active pulmonary tuberculosis," "cure of tuberculosis," and "fecal incontinence;" and, (3) correction of citation references and minor corrections to the text.

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 September 5, 2007, Idaho Administrative Bulletin, Vol. 07-9, pages 98 through 141.

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 to the state's general fund due to this rulemaking is for publication costs only.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Kathryn Turner at (208) 334-5870.

DATED this 26th day of November, 2007.

Sherri Kovach, Program Supervisor
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kovachs@dhw.idaho.gov e-mail

THE FOLLOWING NOTICE PUBLISHED IN 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 39-605, 39-906, 39-1003, 39-1603, 39-4504, 56-1003, and 56-1005, 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 19, 2007.

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 Idaho Reportable Diseases chapter of rules provides for disease surveillance and control and requires specified individuals to report certain diseases and conditions to the Department or Health Districts. These reporting requirements help protect the public from diseases that can be harmful or life-threatening to others if the disease is not reported and contained.

This chapter is being rewritten and reorganized in a more user-friendly and easier-to-understand format for those required to report diseases and conditions in order to increase accuracy and timeliness of reporting. Obsolete language is being removed and the chapter is being updated to reflect changes in disease testing, control measures, reporting requirements and citations.

The chapter is organized to include the following:

1. **General reporting requirements that include who is required to report, where to report, what to report, how to report, and when to report.**

2. **The investigation and handling of the report once it is received and any testing requirements, restrictions, or control measures necessary to prevent the spread of communicable diseases. Procedures for isolation and quarantine orders were written to align with statute.**

3. **Each disease or condition is listed in alphabetical order along with necessary information for the reporting, investigating, and control measures needed for each specific disease. Respiratory Syncytial Virus (RSV) infection was added as a lab-reportable disease.**

The reorganization of the chapter promotes better reporting and will help protect the public through improved compliance with the rule requirements.

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 to the state's general fund due to this rulemaking is for publication costs only.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule change is being made in order to reorganize the existing chapter. Public Health Districts and other stakeholders have been notified and have provided input on the rewrite of the chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kathryn Turner at (208) 334-5870.

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 26, 2007.

DATED this 25th day of July, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16
TITLE 02
CHAPTER 10

16.02.10 - IDAHO REPORTABLE DISEASES

000. LEGAL AUTHORITY.
Sections 39-605, 39-1003, 39-1603, and 56-1005, Idaho Code, grant authority to the Board of Health and Welfare to adopt rules protecting the health of the people of Idaho. Section 39-906, Idaho Code, provides for the Director to administer rules adopted by the Board of Health and Welfare. Section 39-4505(2), Idaho Code, gives the Director authority to promulgate rules regarding the identification of blood- or body fluid-transmitted viruses or diseases. Section 56-1003, Idaho Code, gives the Director the authority to adopt rules protecting the health of the people of Idaho and to recommend rules to the Board of Health and Welfare. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.02.10, "Idaho Reportable Diseases." ( )

02. Scope. These rules contain the official requirements governing the reporting, control, and prevention of reportable diseases and conditions. The purpose of these rules is to identify, control, and prevent the transmission of reportable diseases and conditions within Idaho. ( )

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for these rules. ( )

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

004. DOCUMENTS INCORPORATED BY REFERENCE.
The documents referenced in Subsections 004.01 through 004.06 of this rule are used as a means of further clarifying these rules. These documents are incorporated by reference and are available at the Idaho State Law Library or at the Department's main office listed in Section 005 of these rules. ( )

01. Guideline for Isolation Precautions in Hospitals. Siegel, J.D., et al., "Guideline for Isolation Precautions in Hospitals." Health Care Infection Control Practices Advisory Committee, Atlanta, GA: Centers for Disease Control and Prevention, 2007. ( )

02. Case Definitions for Infectious Conditions Under Public Health Surveillance. Morbidity and Mortality Weekly Report, May 2, 1997, Vol. 46, No. RR-10. Centers for Disease Control and Prevention. ( )

03. Human Rabies Prevention -- United States, 1999. Morbidity and Mortality Weekly Report, January 8, 1999, Vol. 48, RR-1. Centers for Disease Control and Prevention. ( )

04. Public Health Service Guidelines for the Management of Health Care Worker Exposures to HIV and Recommendations for Postexposure Prophylaxis. Morbidity and Mortality Weekly Report, May 15, 1998, Vol. 47, RR-7. Centers for Disease Control and Prevention. ( )

05. Compendium of Animal Rabies Control, 2007. National Association of State Public Health Veterinarians, Inc., Morbidity and Mortality Weekly Report, April 6, 2007, Vol. 58, RR-3. Centers for Disease Control and Prevention. ( )

06. Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary. North American Association of Central Cancer Registries, Twelfth Edition, Record Layout Version 11.2, April 2007. ( )

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.healthand welfare.idaho.gov. ( )

06. Office of Epidemiology and Food Protection. The Department’s Office of Epidemiology and Food Protection is located at 450 West State Street, 4th Floor, Boise, ID 83720; Phone: (208) 334-5939, Fax: (208) 332-7307; http://www.epi.idaho.gov. ( )

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Disclosure of 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. ( )

03. Disclosure of Privacy Information. No employee of the Department or Health District may disclose the identity of persons named in disease reports except to the extent necessary for the purpose of administering the public health laws of this state. ( )

007. -- 009. (RESERVED).

010. DEFINITIONS A THROUGH K.
For the purposes of this chapter, the following definitions apply. ( )

01. Airborne Precautions. Methods used to prevent airborne transmission of infectious agents, as described in "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. ( )

02. Approved Fecal Specimens. Specimens of feces obtained from the designated person who has not taken any antibiotic orally or parenterally for two (2) days prior to the collection of the fecal specimen. The specimen must be collected and transported to the laboratory in a manner appropriate for the test to be performed. ( )

03. Bite or Other Exposure to Rabies. Bite or bitten means that the skin of the person or animal has been nipped or gripped, or has been wounded or pierced, including scratches, and includes probable contact of saliva with a break or abrasion of the skin. The term "exposure" also includes contact of saliva with any mucous membrane. In the case of bats, even in the absence of an apparent bite, scratch, or mucous membrane contact, exposure may have occurred, as described in "Human Rabies Prevention -- United States, 1999," incorporated in Section 004 of these rules. ( )

04. Board. The Idaho State Board of Health and Welfare as described in Section 56-1005, Idaho Code. ( )

05. Cancer Data Registry of Idaho (CDRI). The agency performing cancer registry services under a contractual agreement with the Department as described in Section 57-1703, Idaho Code. ( )

06. Cancers. Cancers that are designated reportable include the following as described in Section 57-1703, Idaho Code: ( )

a. In-situ or malignant neoplasms, but excluding basal cell and squamous cell carcinoma of the skin unless occurring on a mucous membrane and excluding in-situ neoplasms of the cervix. ( )

b. Benign tumors of the brain, meninges, pineal gland, or pituitary gland. ( )

07. Carrier. A carrier is a person who can transmit a communicable disease to another person, but may not have symptoms of the disease. ( )

08. Case. ( )

a. A person, who has been diagnosed as having a specific disease or condition by a physician or other health care provider, is considered a case. The diagnosis may be based on clinical judgment, on laboratory evidence, or on both criteria. Individual case definitions are described in "Case Definitions for Infectious Conditions Under Public Health Surveillance," incorporated in Section 004 of these rules. ( )

b. A laboratory detection of a disease or condition as listed in Section 050 of these rules and as further outlined in Sections 100 through 949 of these rules ( )

09. Cohort System. A communicable disease control mechanism in which cases having the same disease are temporarily segregated to continue to allow supervision and structured attendance in a day care or health care facility. ( )

10. Communicable Disease. A disease which may be transmitted from one (1) person or an animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means which may result in infection, illness, disability, or death. ( )

11. Contact. A contact is a person who has been exposed to a case or a carrier of a communicable disease and could possibly contract the disease or infection. ( )

12. Contact Precautions. Methods used to prevent contact transmission of infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. ( )

13. Day Care. Care and supervision provided for compensation during part of a twenty-four (24) hour day, for a child or children not related by blood or marriage to the person or persons providing the care, in a place other than the child's or children's own home or homes as described by Section 39-1102, Idaho Code. ( )

14. Department. The Idaho Department of Health and Welfare or its designee. ( )

15. Director. The Director of the Idaho Department of Health and Welfare or his designee as described under Sections 56-1003 and 39-414(2), Idaho Code, and Section 950 of these rules. ( )

16. Division of Public Health Administrator. A person appointed by the Director to oversee the administration of the Division of Public Health, Idaho Department of Health and Welfare, or his designee. ( )

17. Droplet Precautions. Methods used to prevent droplet transmission of infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. ( )

18. Exclusion. An exclusion for a food service facility means a person is prevented from working as a food employee or entering a food establishment except for those areas open to the general public as outlined in the IDAPA 16.02.19, "The Idaho Food Code." ( )

19. Extraordinary Occurrence of Illness Including Clusters. Rare diseases and unusual outbreaks of illness which may be a risk to the public are considered an extraordinary occurrence of illness. Illnesses related to drugs, foods, contaminated medical devices, contaminated medical products, illnesses related to environmental contamination by infectious or toxic agents, unusual syndromes, or illnesses associated with occupational exposure to physical or chemical agents may be included in this definition. ( )

20. Fecal Incontinence*. A condition in which temporarily, as with severe diarrhea, or long-term, as with a child or adult requiring diapers, there is an inability to hold feces in the rectum, resulting in involuntary voiding of stool.* *( )*

2*1*. Foodborne Disease Outbreak. An outbreak is when two (2) or more persons experience a similar illness after ingesting a common food. ( )

2*2*. Food Employee. An individual working with unpackaged food, food equipment or utensils, or food-contact surfaces as defined in IDAPA 16.02.19, "The Idaho Food Code." ( )

2*3*. Health Care Facility. An establishment organized and operated to provide health care to three (3) or more individuals who are not members of the immediate family. This definition includes hospitals, intermediate care facilities, residential care and assisted living facilities. ( )

2*4*. Health Care Provider. A person who has direct or supervisory responsibility for the delivery of health care or medical services. This includes: licensed physicians, nurse practitioners, physician assistants, nurses, dentists, chiropractors, and administrators, superintendents, and managers of clinics, hospitals, and licensed laboratories. ( )

2*5*. Health District. Any one (1) of the seven (7) public health districts as established by Section 39-409, Idaho Code, and described in Section 030 of these rules. ( )

2*6*. Health District Director. Any one (1) of the public health districts' directors appointed by the Health District's Board as described in Section 39-413, Idaho Code, or his designee. ( )

2*7*. Idaho Food Code. Idaho Administrative Code that governs food safety, IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments," also known as "The Idaho Food Code." These rules may be found at: http://adm.idaho.gov/adminrules/rules/idapa16/0219.pdf. ( )

2*8*. Isolation. The separation of a person known or suspected to be infected with an infectious agent, or contaminated from chemical or biological agents, from other persons to such places, under such conditions, and for such time as will prevent transmission of the infectious agent or further contamination. The place of isolation will be designated by the Director under Section 56-1003(7), Idaho Code, and Section 065 of these rules. ( )

011. DEFINITIONS L THROUGH Z.

For the purposes of this chapter, the following definitions apply. ( )

01. Laboratory Director. A person who is directly responsible for the operation of a licensed laboratory or his designee. ( )

02. Laboratory. A medical diagnostic laboratory which is inspected, licensed, or approved by the Department or licensed according to the provisions of the Clinical Laboratory Improvement Act by the United States Health Care and Financing Administration. Laboratory may also refer to the Idaho State Public Health Laboratory, and to the United States Centers for Disease Control and Prevention. ( )

03. Livestock. Livestock includes cattle, swine, horses, mules, asses, native and non-native ungulates, and other animals determined by the Department. ( )

04. Medical Record. Hospital or medical records are all those records compiled for the purpose of recording a medical history, diagnostic studies, laboratory tests, treatments, or rehabilitation. Access will be limited to those parts of the record which will provide a diagnosis, or will assist in identifying contacts to a reportable disease or condition. Records specifically exempted by statute are not reviewable. ( )

05. Outbreak. An outbreak is an unusual rise in the incidence of a disease. An outbreak may consist of a single case. ( )

06. Personal Care. The service provided by one (1) person to another for the purpose of feeding, bathing, dressing, assisting with personal hygiene, changing diapers, changing bedding, and other services involving direct physical contact. ( )

07. Physician. A person legally authorized to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho as defined in Section 54-1803, Idaho Code. ( )

08. Quarantine. The restriction placed on the entrance to and exit from the place or premises where an infectious agent or hazardous material exists. The place of quarantine will be designated by the Director or Health District Board. ( )

09. Rabies Post-Exposure Prophylaxis (rPEP). The administration of a rabies vaccine series with or without the antirabies immune globulin, depending on pre-exposure vaccination status, following a documented or suspected rabies exposure, as described in "Human Rabies Prevention--United States, 1999," incorporated in Section 004 of these rules. ( )

10. Rabies-Susceptible Animal. Any animal capable of being infected with the rabies virus. ( )

11. Residential Care Facility. A commercial or non-profit establishment organized and operated to provide a place of residence for three (3) or more individuals who are not members of the same family, but live within the same household. Any restriction for this type of facility is included under restrictions for a health care facility. ( )

12. Restriction. ( )

a. To limit the activities of a person to reduce the risk of transmitting a communicable disease. Activities of individuals are restricted or limited to reduce the risk of disease transmission until such time that they are no longer considered a health risk to others. ( )

b. A food employee who is restricted must not work with exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles. A restricted employee may still work at a food establishment as outlined in the IDAPA 16.02.19, "The Idaho Food Code." ( )

13. Restrictable Disease. A restrictable disease is a communicable disease, which if left unrestricted, may have serious consequences to the public's health. The determination of whether a disease is restrictable is based upon the specific environmental setting and the likelihood of transmission to susceptible persons. ( )

14. Severe Reaction to Any Immunization. Any serious or life-threatening condition which results directly from the administration of any immunization against a communicable disease. ( )

15. Significant Exposure to Blood or Body Fluids. Significant exposure is defined as a percutaneous injury, contact of mucous membrane or non-intact skin, or contact with intact skin when the duration of contact is prolonged or involves an extensive area, with blood, tissue, or other body fluids as defined in "Public Health Service Guidelines for the Management of Health Care Worker Exposures to HIV and Recommendations for Postexposure Prophylaxis," incorporated in Section 004 of these rules. ( )

16. Standard Precautions. Methods used to prevent transmission of all infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. ( )

17. State Epidemiologist. A person employed by the Department to serve as a statewide epidemiologist or his designee. ( )

18. Suspected Case. A person diagnosed with or thought to have a particular disease or condition by a licensed physician or other health care provider. The suspected diagnosis may be based on signs and symptoms, or on laboratory evidence, or both criteria. Suspected cases of some diseases are reportable as described in Section 050 of these rules. ( )

19. Vaccination of an Animal Against Rabies. Vaccination of an animal by a licensed veterinarian with a rabies vaccine licensed or approved for the animal species and administered according to the specifications on the product label or package insert as described in the "Compendium of Animal Rabies Control, 2007," incorporated in Section 004 of these rules. ( )

20. Veterinarian. Any licensed veterinarian as defined in Section 54-2103, Idaho Code. ( )

21. Waterborne Outbreak. An outbreak is when two (2) or more persons experience a similar illness after ingesting water from a common supply and an epidemiological analysis implicates the water as the source of the illness. ( )

22. Working Day. A working day is from 8 a.m. to 5 p.m., Monday through Friday, excluding state holidays. ( )

012. -- 019. (RESERVED).

020. PERSONS REQUIRED TO REPORT REPORTABLE DISEASES, CONDITIONS, AND SCHOOL CLOSURES.

01. Physician. A licensed physician who diagnoses, treats, or cares for a person with a reportable disease or condition must make a report of such disease or condition to the Department or Health District as described in these rules. The physician is also responsible for reporting diseases and conditions diagnosed or treated by physician assistants, nurse practitioners, or others under the physician's supervision. ( )

02. Hospital or Health Care Facility Administrator. The hospital or health care facility administrator must report all persons who are diagnosed, treated, or receive care for a reportable disease or condition in his facility unless the attending physician has reported the disease or condition. ( )

03. Laboratory Director. The laboratory director must report to the Department or Health District the identification of, or laboratory findings suggestive of, the presence of the organisms, diseases, or conditions listed in Section 050 of these rules. ( )

04. School Administrator. A school administrator must report diseases and conditions to the Department or Health District as indicated in Section 050 of these rules. A school administrator must report the closure of any public, parochial, charter, or private school within one (1) working day when, in his opinion, such closing is related to a communicable disease. ( )

05. Persons in Charge of Food Establishments. If the person in charge of the eating or drinking establishment has reason to suspect that any employee has a disease listed in Section 050 of these rules that is in a communicable form, he must immediately notify the Department or Health District and obtain guidance on proper actions needed to protect the public. ( )

06. Others Required to Report Reportable Diseases. In addition to licensed physicians, reports must also be made by physician assistants, certified nurse practitioners, registered nurses, school health nurses, infection surveillance staff, public health officials, and coroners. ( )

021. ACCESS TO MEDICAL RECORDS.
No physician, hospital administrative person, or patient may deny the Department, Health Districts, or the Board access to medical records in discharge of their duties in implementing the reportable disease rules. ( )

022. PENALTY PROVISIONS.
These rules may be enforced under the civil and criminal penalties described in Sections 39-108, 39-109, 39-607, 39-1006, 39-1606, and 56-1008, Idaho Code, and other applicable statutes and rules. Penalties may include fines and imprisonment as specified in Idaho Code. ( )

023. DELEGATION OF POWERS AND DUTIES.
The Director has the authority to delegate to the Health Districts any of the powers and duties created by these rules under Section 39-414(2), Idaho Code. Any delegation authority will be in writing and signed by the both the Director and the Health District Board. ( )

024. -- 029. (RESERVED).

030. WHERE TO REPORT REPORTABLE DISEASES AND CONDITIONS.
Subsections 030.01 through 030.09 of this rule provide where information for reporting of suspected, identified, and diagnosed diseases and conditions are to be reported. The diseases and conditions in Sections 100 through 949 of these rules are reportable to the agencies listed in Subsections 030.01 through 030.09 of this rule. ( )

01. Department of Health and Welfare, Office of Epidemiology and Food Protection. ( )

a. Main Office Address: 450 West State Street, 4th Floor, Boise, ID 83720. ( )

b. Phone: (208) 334-5939 and FAX: (208) 332-7307. ( )

02. Health District I - Panhandle Health District. The Panhandle Health District covers the counties of Benewah, Bonner, Boundary, Kootenai, and Shoshone. ( )

a. Main Office Address: 8500 N. Atlas Road, Hayden, ID 83835. ( )

b. Phone: (208) 771-0271 and FAX: 1-866-716-2599 Toll Free. ( )

03. Health District II - North Central District Health Department. The North Central District Health Department covers the counties of Clearwater, Idaho, Latah, Lewis, and Nez Perce. ( )

a. Main Office Address: 215 10th Street, Lewiston, ID 83501. ( )

b. Phone: (208) 799-3100 and FAX: (208) 799-0349. ( )

04. Health District III - Southwest District Health Department. The Southwest District Health Department covers the counties of Adams, Canyon, Gem, Owyhee, Payette, and Washington. ( )

a. Main Office Address: 920 Main Street, Caldwell, ID 83605. ( )

b. Phone: (208) 455-5362 and FAX: (208) 455-5350. ( )

05. Health District IV - Central District Health Department. The Central District Health Department covers the counties of Ada, Boise, Elmore and Valley. ( )

a. Main Office Address: 707 N. Armstrong Place, Boise, ID 83704. ( )

b. Phone: (208) 327-8625 and FAX: (208) 327-7100. ( )

06. Health District V - South Central District Health Department. The South Central District Health Department covers the counties of Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls. ( )

a. Main Office Address: 1020 Washington Street N., Twin Falls, ID 83301. ( )

b. Phone: (208) 737-5936 or (208) 737-5974 and FAX: (208) 736-3009. ( )

07. Health District VI - Southeastern District Health Department. The Southeastern District Health Department covers the counties of Bannock, Bear Lake, Bingham, Butte, Caribou, Franklin, Oneida, and Power. ( )

a. Main Office Address: 1901 Alvin Ricken Drive, Pocatello, ID 83201. ( )

b. Phone: (208) 233-9080 and FAX: (208) 233-1916. ( )

08. Health District VII - Eastern Idaho Public Health Department. The Eastern Idaho Public Health Department covers the counties of Bonneville, Clark, Custer, Fremont, Jefferson, Lemhi, Madison and Teton. ( )

a. Main Office Address: 254 E Street, Idaho Falls, ID 83402. ( )

b. Phone: (208) 522-0310 and FAX: (208) 525-7063. ( )

09. Cancer Data Registry of Idaho (CDRI). ( )

a. Main Office Address: 615 N. 7th Street, P.O. Box 1278, Boise, ID 83701. ( )

b. Phone: (208) 338-5100. ( )

10. Inter-Agency Notification. The Health District must notify the Department of reportable diseases and conditions as provided in Section 050 of these rules. ( )

a. The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case of a reportable disease or condition when required in Sections 100 through 949 of these rules. ( )

b. The Department and the Health District will exchange reported information no later than weekly of all other cases of reportable diseases and conditions as specified under each disease or condition. ( )

c. The Department will notify the Idaho Department of Agriculture of any identified or suspected source of an animal related disease when required in Sections 100 through 949 of these rules. ( )

031. -- 039. (RESERVED).

040. REPORT CONTENTS AND METHOD OF REPORTING.

01. Report Contents. Each report of a reportable disease or condition must include: ( )

a. The identity and address of the attending licensed physician or the person reporting; ( )

b. The diagnosed or suspected disease or condition; ( )

c. The name, current address, telephone number, birth date, age, race, ethnicity, and sex of the individual with the disease or other identifier from whom the specimen was obtained; ( )

d. The date of onset of the disease or the date the test results were received; and ( )

e. In addition, laboratory directors must report the identity of the organism or other significant test result. ( )

02. How To Report. A report of a case or suspected case may be made to the Department or Health District by telephone, mail, fax, or through electronic-disease reporting systems as listed in Sections 005 and 030 of these rules. ( )

03. After Hours Notification. To report a disease after hours use the State Communications public health paging system (State Comm) at (800) 632-8000. A public health official will be paged immediately to assist you. ( )

041. -- 049. (RESERVED).

050. REPORTABLE OR RESTRICTABLE DISEASES, CONDITIONS AND REPORTING REQUIREMENTS.

Reportable diseases and conditions must be reported to the Department or Health District by those required under Section 020 of these rules. The table below identifies the reportable and restrictable diseases and conditions, the timeframe for reporting, and the person or facility required to report.

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Acquired Immune Deficiency Syndrome (AIDS), (including CD-4 lymphocyte counts <200 cells/mm3 blood or ≤ 14%)	100	Within 3 working days	None	
Amebiasis	110	Within 3 working days	DC, FS, HC	Day Care Facility Food Service Facility
Anthrax (bacillus anthracis)	120	Immediately	None	
Biotinidase Deficiency	130	Within 1 working day (in newborn screening)	None	
Botulism	140	Immediately	None	
Brucellosis (Brucella species)	150	Within 1 working day	None	
Campylobacteriosis (Campylobacter species)	160	Within 3 working days	DC, FS, HC	Day Care Facility Food Service Facility
Cancer	170	Report to Cancer Data Registry of Idaho within 180 days of diagnosis or recurrence (including suspected cases)	None	
Chancroid	180	Within 3 working days	None	
Chlamydia trachomatis Infections	190	Within 3 working days	HC	
Cholera (Vibrio cholerae)	200	Within 1 working day	FS, HC, DC	Food Service Facility
Congenital Hypothyroidism	210	Within 1 working day (in newborn screening)	None	
Conjunctivitis	080, 090	No reporting required	DC, S	
Cryptosporidiosis (Cryptosporidium species)	220	Within 3 working days	FS, HC, DC	
Cutaneous Fungal Infections	080, 090	No reporting required	DC, S	
Diarrhea (until common communicable diseases have been ruled out)	085	No reporting required	FS	
Diphtheria (Corynebacterium diphtheriae)	230	Immediately	DC, FS, HC, S	Day Care Facility School

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Encephalitis, Viral or Aseptic	240	Within 3 working days	None	
Escherichia coli O157:H7 and other Shiga-Toxin Producing E. coli (STEC)	250	Within 1 working day	DC, FS, HC	Day Care Facility Food Service Facility School
Extraordinary Occurrence of Illness, including Clusters	260	Within 1 working day	None	
Fever	085	No reporting required	FS	
Food Poisoning, Foodborne Illness, and Waterborne Illnesses	270	Within 1 working day	None	
Galactosemia	280	Within 1 working day (in newborn screening)	None	
Giardiasis (Giardia lamblia)	290	Within 3 working days	DC, FS, HC	Day Care Facility Food Service Facility
Haemophilus influenzae Invasive Disease	300	Within 1 working day	DC, S	Day Care Facility School
Hantavirus Pulmonary Syndrome	310	Within 1 working day	None	
Hemolytic-Uremic Syndrome (HUS)	320	Within 1 working day	None	
Hepatitis A	330	Within 1 working day	DC, FS, HC	Day Care Facility Food Service Facility
Hepatitis B	340	Within 1 working day	None	
Hepatitis C	350	Within 3 working days	None	
Human Immunodeficiency Virus (HIV)	360	Within 3 working days	None	
Human T-Lymphotropic Virus	370	Within 3 working days	None	
Jaundice	085	No reporting required	FS	
Lead Levels of Ten Micrograms or more per Deciliter of Whole Blood (ug/dL)	380	Within 3 working days	None	
Legionellosis	390	Within 3 working days	None	
Leprosy (Hansen's Disease)	400	Within 3 working days	None	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Leptospirosis	410	Within 3 working days	None	
Listeriosis (Listeria species)	420	Within 3 working days	None	
Lyme Disease	430	Within 3 working days	None	
Malaria (Plasmodium species)	440	Within 3 working days	None	
Maple Syrup Urine Disease	450	Within 1 working day (in newborn screening)	None	
Measles (Rubeola)	460	Within 1 working day	DC, HC, S	Day Care Facility School
Meningitis, Viral or Aseptic	470	Within 3 working days	None	
Methicillin-resistant Staphylococcus aureus (MRSA) Invasive Disease	*475*	*Within 3 working days*	*None*	***Note:*** *Only Laboratory Directors need to report.*
Methicillin-resistant Staphylococcus aureus (MRSA) Non-Invasive Disease	*475, 080, 090*	*No reporting required*	*DC, FS, HC, S*	
Mumps	480	Within 3 working days	DC, S, HC	Day Care Facility School
Myocarditis, Viral	490	Within 3 working days	None	
Neisseria gonorrhoeae Infections	500	Within 3 working days	*None*	
Neisseria meningitidis Invasive Disease	510	Within 1 working day	DC, HC, S	Day Care Facility School
Norovirus	520	Within 1 working day	DC, FS, HC, S	
Pediculosis	080, 090	No reporting required	DC, S	
Pertussis (Bordetella pertussis)	530	Within 1 working day	DC, HC, S	Day Care Facility School
Phenylketonuria (PKU)	540	Within 1 working day (in newborn screening)	None	
Plague (Yersinia pestis)	550	Immediately	HC, S	Day Care Facility School

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Pneumococcal Invasive Disease in Children less than Eighteen (18) Years of Age (Streptococcus pneumoniae)	560	Within 3 working days	DC, S	Day Care Facility School
Pneumocystis Pneumonia (PCP)	570	Within 3 working days	*None*	
Poliomyelitis	580	Within 1 working day	DC	Day Care Facility School
Psittacosis	590	Within 3 working days	*None*	
Q Fever	600	Within 1 working day	*None*	
Rabies -- Human and Animal	610	Immediately (human), Within 1 working day (animal)	*None*	
Relapsing Fever, Tick-borne and Louse-borne	620	Within 3 working days	*None*	
Respiratory Syncytial Virus (RSV)	630	Within 1 working day	*None*	**Note:** Only Lab*oratory Directors* need to report.
Reye Syndrome	640	Within 3 working days	*None*	
Rocky Mountain Spotted Fever	650	Within 3 working days	*None*	
Rubella (including Congenital Rubella Syndrome)	660	Within 1 working day	DC, HC, S	Day Care Facility School
Salmonellosis (including Typhoid Fever) (Salmonella species)	670	Within 1 working day	DC, FS, HC	Day Care Facility Food Service Facility
Scabies	080, 090	No reporting required	DC, S	
Severe Acute Respiratory Syndrome (SARS)	680	Within 1 working day	DC, S	Day Care Facility School
Severe Reaction to Any Immunization	690	Within 1 working day	*None*	
Shigellosis (Shigella species)	700	Within 1 working day	DC, FS, HC, S	Day Care Facility Food Service Facility School
Smallpox	710	Immediately	DC, HC, S	Day Care Facility School

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Day Care FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Sore Throat with Fever	085	No reporting required	FS	
Staphylococcal Infections *other than MRSA*	080, 090	No reporting required	DC, *FS,* S	
Streptococcal Pharyngeal Infections	080, 090	No reporting required	DC, S	
Streptococcus pyogenes (Group A Strep), Invasive or Resulting in Rheumatic Fever	720	Within 3 working days	DC, HC, S	Day Care Facility School
Syphilis	730	Within 3 working days	None	
Taeniasis	085	No reporting required	FS	
Tetanus	740	Within 3 working days	None	
Toxic Shock Syndrome	750	Within 3 working days	None	
Transmissible Spongiform Encephalopathies (TSE), including Creutzfeldt-Jakob Disease (CJD) and Variant CJD (vCJD)	760	Within 3 working days	None	
Trichinosis	770	Within 3 working days	None	
Tuberculosis (Mycobacterium tuberculosis)	780	Within 3 working days	DC, FS, HC, S	Day Care Facility School Food Service Facility
Tularemia (Francisella tularensis)	790	Immediately; Identification of Francisella tularensis - within 1 working day	None	
Uncovered and Open or Draining Skin Lesions with Pus, such as a Boil or Open Wound	085	No reporting required	FS	
Varicella (chickenpox)	080, 090	No reporting required	DC, S	
Vomiting (until noninfectious cause is identified)	085	No reporting required	FS	
West Nile Virus (WNV)	800	Within 3 working days	None	
Yersiniosis (Yersinia enterocolitica and Yersinia pseudotuberculosis)	810	Within 3 working days; Identification of Yersinia pestis - immediately	FS	

( )

051. -- 059. (RESERVED).

060. TESTING FOR CERTAIN REPORTABLE DISEASES WHEN INFORMED CONSENT IS NOT POSSIBLE.
Under Section 39-4504, Idaho Code, a licensed physician may order blood or body fluid tests for hepatitis viruses, malaria, syphilis, or the human immunodeficiency virus (HIV) when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

061. -- 064. (RESERVED).

065. INVESTIGATION AND CONTROL OF REPORTABLE DISEASES.

01. Responsibility and Authority. The Department will use all reasonable means to confirm in a timely manner any case or suspected case of a reportable disease or condition, and will determine, when possible, all sources of infection and the extent of exposure. Investigations may be made when the Division of Public Health Administrator, Health District Director, or state epidemiologist determines a disease to be of public health significance. ( )

a. Every licensed physician or other health care provider attending a person with a reportable disease or condition must report the case or suspected case, as described in Section 050 of these rules. He must instruct the person on applicable control measures as outlined in Sections 100 through 949 of these rules and cooperate with the Department in the investigation and control of the disease or condition. ( )

b. Any person providing emergency or medical services who believes he has experienced a significant exposure to blood or bodily fluids as defined in Subsection 011.15 of these rules may report said exposure as soon as possible or within fourteen (14) days of the occurrence to the Department on a significant exposure report form. When, in the state epidemiologist's judgment, a significant exposure has occurred, the Department will inform the exposed individual that he may have been exposed to the HIV or HBV virus, or that there is no information available based on the Department's current HIV or HBV registry and will recommend appropriate counseling and testing for the exposed individual. ( )

02. Inspection - Right of Entry. The Department may enter private or public property for the purpose of administering or enforcing the provisions of these rules under the authority and constraints granted by Section 56-1009, Idaho Code. ( )

03. Inviolability of Placards. If it is necessary to use placards, it is unlawful for any person to interfere with, conceal, mutilate or tear down any notices or placards on any house, building or premises placed by the Department. Such placards can only be removed by the health official. ( )

04. Verification of Diagnosis. Cases of diseases or conditions reported to the Department will be treated as such upon the statement of the attending licensed physician or other health care provider, unless there is reason to doubt the diagnosis. Final decision as to the

diagnosis for administrative purposes will rest with the Division of Public Health Administrator or Health District Director. ( )

05. Closure of Schools and Places of Public Assembly. The Director may order the closing of any public, parochial, or private school, or other place of public assembly when, in his opinion, such closing is necessary to protect public health. The school or other place of public assembly must not reopen until permitted by the health official. ( )

06. Transportation of Patients With Communicable Disease. No person with a reportable disease in a communicable form, who is under orders of isolation, nor any contact who is restricted under an order of quarantine, may travel or be transported from one place to another without the permission of the Division of Public Health Administrator or Health District Director. An exception may be made in instances where the patient is to be admitted directly to a hospital or treatment facility, provided adequate precautions are taken to prevent dissemination of the disease by the patient enroute to the hospital or treatment facility. ( )

07. Order to Report for Examination. The Division of Public Health Administrator or Health District Director may issue an order to report for examination. An order to report for examination must be served by delivering one (1) copy to the person to be examined, one (1) copy to the prosecuting attorney of the county or city in which the person resides, and filing one (1) copy bearing the notation of time and place of service and the signature of the person serving the notice with the issuing health authority. ( )

08. Order for Isolation. The Division of Public Health Administrator or Health District Director may issue and withdraw an order for isolation if he determines that it is necessary to protect the public from a significant risk of the spread of infectious or communicable diseases or from contamination from chemical or biological agents. Orders for isolation must be executed as described in Subsections 065.08.a. and 065.08.b. of this rule. ( )

a. The order for isolation must be executed as follows: ( )

i. One (1) copy to the individual being isolated; ( )

ii. One (1) copy to the attending licensed physician; ( )

iii. One (1) copy to the prosecuting attorney of the county or city in which the person resides; and ( )

iv. One (1) copy to be filed in the office of the issuing officer along with an affidavit of service signed by the person who served the order. ( )

b. The issuing officer will make an assessment and identify the least restrictive means of isolation that effectively protects unexposed and susceptible individuals from the public health threat. Orders of isolation require the individual to isolate himself at a certain place or places, and may require specific precautions to be taken when outside a designated place of isolation as the issuing officer deems appropriate and necessary. If the place of isolation is other than the individual's place of residence, a copy of the order must be provided to the person in charge of that place. ( )

c. The Division of Public Health Administrator or Health District Director will withdraw an order for isolation once it is determined there is no longer a significant threat to the public's health posed by the individual under order for isolation. ( )

09. Order for Quarantine. The Division of Public Health Administrator or Health District Director is empowered whenever a case of any communicable disease occurs in any household or other place within his jurisdiction and in his opinion it is necessary that persons residing within must be kept from contact with the public, to declare the house, building, apartment, or room a place of quarantine and to require that no persons will leave or enter during the period of quarantine except with specific permission of the issuing officer. Orders for quarantine must be executed as described in Subsections 065.09.a. and 065.09.b. of this rule. ( )

a. The order for quarantine must be executed as follows: ( )

i. One (1) copy to any individual being quarantined; ( )

ii. One (1) copy to the attending licensed physician; ( )

iii. One (1) copy to the prosecuting attorney of the county or city in which the quarantine occurs; ( )

iv. One (1) copy to be filed in the office of the issuing officer along with an affidavit of service signed by the person who served the order; and ( )

v. One (1) copy to the person in charge or owner of the place of quarantine. ( )

b. The issuing officer will make an assessment and identify the least restrictive timeframe of quarantine that effectively protects unexposed and susceptible individuals to the infection of public health threat. ( )

c. The Division of Public Health Administrator or Health District Director will withdraw an order for quarantine when he determines there is no longer a significant threat to the public's health posed by the individual or premises under the order for quarantine. ( )

10. Sexually Transmitted Infection Contacts. Any person infected with a sexually transmitted infection (venereal disease) as defined in Section 39-601, Idaho Code, is required to provide the name, address, and telephone number(s) of all persons from whom the disease may have been acquired and to whom the disease may have been transmitted, when such information is requested by the Department or Health District. ( )

066. -- 069. (RESERVED).

070. SPECIAL DISEASE INVESTIGATIONS.
The Department may conduct special investigations of diseases or conditions to identify causes and means of prevention. All records of interviews, reports, studies, and statements obtained by or furnished to the Department or other authorized agency are confidential for the identity of all

persons involved. Release of information to the Department as required or permitted by these rules does not subject any party furnishing such information to an action for damages as provided under IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

071. -- 079. (RESERVED).

080. DAY CARE FACILITY - REPORTING AND CONTROL MEASURES.

01. Readily Transmissible Diseases. Day care reportable and restrictable diseases are those diseases that are readily transmissible among children and staff in day care facilities as listed under Section 050 of these rules. ( )

02. Restrictable Disease - Employee. A person who is diagnosed to have a day care restrictable disease must not work in any occupation in which there is direct contact with children in a day care facility, as long as the disease is in a communicable form. ( )

03. Restrictable Disease - Child. A child who is diagnosed to have a day care restrictable disease must not attend a day care facility as long as the disease is in a communicable form. This restriction may be removed by the written certification of a licensed physician, public health nurse or school nurse that the person's disease is no longer communicable. ( )

04. Prevention of the Transmission of Disease. When satisfactory measures have been taken to prevent the transmission of disease, the affected child or employee may continue to attend or to work in a day care facility if approval is obtained from the Department or Health District. ( )

081. -- 084. (RESERVED).

085. FOOD SERVICE FACILITY - REPORTING AND CONTROL MEASURES.

01. Food or Beverage Transmitted Disease in a Communicable Form. Under Section 050 of these rules, a person who is diagnosed to have one (1) or more of the diseases or conditions listed as restrictable for food establishments must not work as a food employee as long as the disease is in a communicable form. ( )

02. Food Employee Health Examination. The Division of Public Health Administrator may require a food employee to submit to an examination to determine the presence of a disease that can be transmitted by means of food when there is reasonable cause to believe the food employee is afflicted with a disease listed in Section 050 of these rules as restrictable for food establishments, and that disease is in a communicable form. ( )

03. Notification of Disease in a Communicable Form. If the person in charge of an eating or drinking establishment has reason to suspect that any employee has a disease listed in Section 050 of these rules as restrictable for food establishments, and that disease is in a communicable form, the person in charge must immediately notify the Department or Health District and obtain guidance on proper actions needed to protect the public. ( )

086. -- 089. (RESERVED).

090. SCHOOL - REPORTING AND CONTROL MEASURES.

01. Restrictable Diseases. School reportable and restrictable diseases are those diseases that are readily transmissible among students and staff in schools as listed under Section 050 of these rules. ( )

02. Restrictions - Work. Any person who is diagnosed to have a school restrictable disease must not work in any occupation that involves direct contact with students in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

03. Restrictions - Attendance. Any person who is diagnosed with or reasonably suspected to have a school restrictable disease must not attend a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

04. Determination Disease Is No Longer Communicable. A licensed physician, public health nurse, school nurse or other person designated by the Department or Health District may determine when a person with a school restrictable disease can no longer transmit the disease to others. ( )

05. School Closure. A school administrator must report the closure of any public, parochial, charter, or private school within one (1) working day when, in his opinion, such closing is related to a communicable disease. ( )

091. -- 099. (RESERVED).

REPORTABLE DISEASES AND CONTROL MEASURES

(SECTIONS 100 - 949)

100. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

01. Reporting Requirements. Each case of acquired immune deficiency syndrome (AIDS) that meets the current case definition established by the Centers for Disease Control and Prevention must be reported to the Department or Health District within three (3) working days of identification. Positive laboratory tests for HIV Antibody, HIV Antigen (protein or nucleic acid), HIV culture or other tests that indicate prior or existing HIV infection or CD-4 lymphocyte counts of less than two hundred (200) per cubic millimeter (mm3) of blood or less than or equal to fourteen percent (14%) must be reported. ( )

02. Investigation. Each reported case of AIDS must be investigated to obtain specific clinical information, to identify possible sources, risk factors, and contacts. Other manifestations of HIV infection as defined by the Centers for Disease Control and Prevention may be investigated. ( )

101. -- 109. (RESERVED).

110. AMEBIASIS.

01. Reporting Requirements. Each case of amebiasis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of amebiasis must be investigated to determine whether the person with amebiasis is employed as a food employee, provides personal care at a health care or day care facility, or is a child attending a day care facility. ( )

03. Restrictions - Day Care Facility. A person excreting Entamoeba histolytica must not attend a day care facility while fecally incontinent and must not work in any occupation in which they provide personal care to children in a day care facility, unless an exemption is made by the Department or Health District. ( )

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or ( )

b. At least two (2) approved fecal specimens collected at least twenty-four (24) hours apart fail to show Entamoeba histolytica upon testing by a licensed laboratory. ( )

04. Restrictions - Food Service Facility. A symptomatic person excreting Entamoeba histolytica is restricted from working as a food employee. ( )

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or ( )

b. At least two (2) approved fecal specimens collected at least twenty-four (24) hours apart fail to show Entamoeba histolytica upon testing by a licensed laboratory. ( )

05. Restrictions - Health Care Facility. A person excreting Entamoeba histolytica must not work in any occupation in which they provide personal care to persons confined to a health care facility, unless an exemption is made by the Department or Health District. ( )

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or ( )

b. At least two (2) approved fecal specimens collected at least twenty-four (24) hours apart fail to show Entamoeba histolytica upon testing by a licensed laboratory. ( )

06. Restrictions - Household Contacts. A member of the household in which there is a case of amebiasis may not work in any occupations in Subsections 110.03 through 110.05 of this rule, unless approved by the Department or Health District. The household member must be asymptomatic and have at least one (1) approved fecal specimen found to be negative for ova and parasites on examination by a licensed laboratory prior to being approved for work. ( )

111. -- 119. (RESERVED).

120. ANTHRAX.

01. Reporting Requirements. Each case or suspected case of anthrax in humans must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of anthrax must be investigated to confirm the diagnosis, determine the extent of the outbreak, and identify the source of infection. ( )

03. Handling of Report. The Department and Health District will exchange reported information within one (1) working day of any reported case of anthrax. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of anthrax. ( )

121. -- 129. (RESERVED).

130. BIOTINIDASE DEFICIENCY.
Each case or suspected case of biotinidase deficiency must be reported to the Department or Health District within one (1) working day of identification. ( )

131. -- 139. (RESERVED).

140. BOTULISM.

01. Reporting Requirements. Each case or suspected case of botulism must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of botulism must be investigated to confirm the diagnosis, determine if other persons have been exposed to botulinum toxins, and identify the source of the disease. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of botulism. ( )

141. -- 149. (RESERVED).

150. BRUCELLOSIS.

01. Reporting Requirements. Each case of brucellosis must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of brucellosis must be investigated to confirm the diagnosis and identify the source of the disease. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day of any reported case of brucellosis. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of the disease. ( )

151. -- 159. (RESERVED).

160. CAMPYLOBACTERIOSIS.

01. Reporting Requirements. Each case of campylobacteriosis must be reported to Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of campylobacteriosis must be investigated to determine the extent of the outbreak and identify the source of the disease. ( )

03. Restrictions - Day Care Facility. A person excreting Campylobacter must not provide personal care in a day care and an fecally incontinent person excreting Campylobacter must not attend a day care facility unless an exemption is obtained from the Department or Health District. Before returning to work or day care, the person must provide at least two (2) approved fecal specimens, collected at least twenty-four (24) hours apart, that fail to show Campylobacter upon testing by a licensed laboratory. ( )

04. Restrictions - Food Service Facility. A symptomatic person excreting Campylobacter is restricted from working as a food employee. ( )

05. Restrictions - Health Care Facility. A person excreting Campylobacter must not provide personal care to persons in a health care facility unless an exemption is obtained from the Department or Health District. Before returning to work, the person must provide at least two (2) approved fecal specimens, collected at least twenty-four (24) hours apart, that fail to show Campylobacter upon testing by a licensed laboratory. ( )

161. -- 169. (RESERVED).

170. CANCER.

01. Reporting Requirements. Cancer is to be reported within one hundred and eighty (180) days of its diagnosis or recurrence to the Cancer Data Registry of Idaho (CDRI). ( )

02. Handling of Report. All data reported to the CDRI is available for use in aggregate form for epidemiologic analysis of the incidence, prevalence, survival, and risk factors associated with Idaho's cancer experience. Disclosure of confidential information for research projects must comply with the CDRI's confidentiality policies as well as IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

03. Cancers Designated as Reportable. Cancers that are designated reportable to the CDRI include the following as described in Section 57-1703, Idaho Code. ( )

a. Each in-situ or malignant neoplasm diagnosed by histology, radiology, laboratory testing, clinical observation, autopsy, or suggested by cytology is reportable, excluding basal cell and squamous cell carcinoma of the skin unless occurring on a mucous membrane and excluding in-situ neoplasms of the cervix. ( )

b. Benign neoplasms are reportable if occurring in the central nervous system including the brain, meninges, pineal gland, or pituitary gland. ( )

c. The use of the words "apparently," "appears to," "comparable with," "compatible with," "consistent with," "favor," "malignant appearing," "most likely," "presumed," "probable," "suspected," "suspicious," or "typical" is sufficient to make a case reportable. ( )

d. The use of the words "questionable," "possible," "suggests," "equivocal," "approaching," "rule out," "potentially malignant," or "worrisome," is not sufficient to make a case reportable. ( )

04 Report Content. Each reported case must include the patient's name, demographic information, date of diagnosis, primary site, metastatic sites, histology, stage of disease, initial treatments, subsequent treatment, and survival time. Reporting of cases must adhere to cancer reporting standards as provided in "Standards for Cancer Registries, Vol. II." as incorporated by reference in Section 004 of these rules. ( )

05. Reported By Whom. Every private, federal, or military hospital, out-patient surgery center, radiation treatment center, pathology laboratory, or physician providing a diagnosis or treatment related to a reportable cancer is responsible for reporting or furnishing cancer-related data, including annual follow-up, to CDRI. ( )

171. -- 179. (RESERVED).

180. CHANCROID.

01. Reporting Requirements. Each case of chancroid must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation and Notification of Contacts. Each reported case of chancroid must be investigated to determine the source and extent of contact follow-up that is required. Each person diagnosed with chancroid is required to inform his sexual contacts that they have been exposed to a sexually transmitted infection, or to provide specific information to health officials in order to locate these contacts. The contacts must be notified of the disease in order to be examined and treated according to Section 39-605, Idaho Code. ( )

181. -- 189. (RESERVED).

190. CHLAMYDIA TRACHOMATIS.

01. Reporting Requirements. Each case of Chlamydia trachomatis infection must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of Chlamydia trachomatis pelvic inflammatory disease must be investigated to determine the extent of contact follow-up that is required. ( )

03. Prophylaxis of Newborns. Prophylaxis against Chlamydia trachomatis

ophthalmia neonatorum is required in IDAPA 16.02.12, "Rules Governing Procedures and Testing To Be Performed on Newborn Infants." ( )

04. Restrictions - Health Care Facility. Cases of Chlamydia trachomatis ophthalmia neonatorum in a health care facility will be placed under contact isolations. ( )

191. -- 199. (RESERVED).

200. CHOLERA.

01. Reporting Requirements. Each case or suspected case of cholera must be reported to the Department or Health District within one (1) working day. ( )

02. Investigation. Each reported case of cholera must be investigated to confirm the diagnosis, determine the extent of the outbreak, and identify contacts, carriers, and the source of the infection. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of cholera. ( )

04. Restrictions - Day Care Facility. A person excreting Vibrio cholerae must not attend a day care facility while fecally incontinent and must not work in any occupation that provides personal care to children in a day care facility while the disease is in a communicable form, unless an exemption is obtained from the Department or Health District. ( )

05. Restrictions - Food Service Facility. A symptomatic person excreting Vibrio cholerae is restricted from working as a food employee under IDAPA 16.02.19, "The Idaho Food Code." ( )

06. Restrictions - Health Care Facility. A person excreting Vibrio cholerae must not work in any occupation that provides personal care to persons confined in a health care or residential facility while in a communicable form, unless an exemption is obtained from the Department or Health District. A person in a health care facility who has cholera must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

07. Restrictions - Household Contacts. A member of the household in which there is a case of cholera may not work in any occupations listed in Subsections 200.04 through 200.06 of this rule, unless approved by the Department or Health District. The household member must be asymptomatic and provide at least one (1) approved fecal specimen found to be negative on a culture by a licensed laboratory prior to being approved for work. ( )

201. -- 209. (RESERVED).

210. CONGENITAL HYPOTHYROIDISM.
Each case or suspected case of congenital hypothyroidism must be reported to the Department or Health District within one (1) working day of identification. ( )

211. -- 219. (RESERVED).

220. CRYPTOSPORIDIOSIS.

01. Reporting Requirements. Each case of cryptosporidiosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case must be investigated to determine the extent of the outbreak and identify the source of the infection. ( )

03. Restrictions - Day Care Facility. A fecally incontinent person excreting Cryptosporidium parvum must not attend a day care facility. A person excreting Cryptosporidium parvum must not provide personal care in a day care facility, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: ( )

a. At least two (2) approved fecal specimens collected at least twenty-four (24) hours apart fail to show Cryptosporidium upon testing by a licensed laboratory; or ( )

b. Diarrhea has ceased for twenty-four (24) hours. ( )

04. Restrictions - Food Service Facility. A symptomatic person excreting Cryptosporidium parvum is restricted from working as a food employee. ( )

05. Restrictions - Health Care Facility. A person excreting Cryptosporidium parvum must not provide personal care in a custodial institution, or health care facility while fecally incontinent, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: ( )

a. At least two (2) approved fecal specimens collected at least twenty-four (24) hours apart fail to show Cryptosporidium upon testing by a licensed laboratory; or ( )

b. Diarrhea has ceased for twenty-four (24) hours. ( )

221. -- 229. (RESERVED).
230. DIPHTHERIA.

01. Reporting Requirements. Each case or suspected case of diphtheria must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation and Response. Each reported case of diphtheria must be investigated to determine if the illness is caused by a toxigenic strain of Corynebacterium diphtheriae, the extent of the outbreak, and identify contacts, carriers, and the source of the infection. Contacts of a person with toxigenic diphtheria will be offered immunization against diphtheria. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case of

diphtheria. ( )

04. Restrictions - Health Care Facility. ( )

a. A person with oropharyngeal toxigenic diphtheria in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. The Department or Health District may withdraw this isolation requirement after two (2) cultures of the nose and two (2) cultures from the throat, taken at least twenty-four (24) hours apart and at least twenty-four (24) hours after the completion of antibiotic therapy, fail to show toxigenic Corynebacterium diphtheriae upon testing by a licensed laboratory. ( )

b. A person with cutaneous toxigenic diphtheria must be placed under contact precautions. The Department of Health District may withdraw these precautions after two (2) cultures from the wound fail to show toxigenic Corynebacterium diphtheriae upon testing by a licensed laboratory. ( )

05. Restrictions - Contacts. Contacts of a person with toxigenic diphtheria are restricted from working as food employees, working in health care facilities, or from attending or working in day care facilities or schools until they are determined not to be carriers by means of a nasopharyngeal culture or culture of other site suspected to be infected. These restrictions may be withdrawn by the Department or Health District. ( )

231. -- 239. (RESERVED).

240. ENCEPHALITIS, VIRAL OR ASEPTIC.

01. Reporting Requirements. Each case of viral or aseptic encephalitis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of viral or aseptic encephalitis and meningitis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection. ( )

241. -- 249. (RESERVED).

250. ESCHERICHIA COLI O157:H7 AND OTHER SHIGA-TOXIN PRODUCING E. COLI (STEC).

01. Reporting Requirements. Each case or suspected case of Escherichia coli O157:H7 or other Shiga-toxin producing E. coli (STEC) must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case must be investigated to determine if the person is employed as a food employee, provides personal care at a health care or day care facility, or is a child attending a day care facility. The investigation determines the extent of the outbreak and identifies the most likely source of the infection. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of E. coli O157:H7 or other shiga-toxin producing E. coli (STEC). ( )

04. Restrictions - Day Care Facility. A person who is excreting E. coli O157:H7 or other STEC must not attend day care facilities while fecally incontinent or provide personal care to children in a day care facility while the disease is present in a communicable form without the approval of the Department or Health District. Two (2) fecal specimens negative for E. coli O157:H7 or other STEC are sufficient to remove this restriction. ( )

05. Restrictions - Food Service Facility. A person diagnosed to have E. coli O157:H7 or other STEC which can be transmitted from one (1) person to another through food or beverage must not work as a food employee as long as the disease is in a communicable form. Food employees must be managed under IDAPA 16.02.19, "The Idaho Food Code." ( )

06. Restrictions - Health Care Facility. A person who is excreting E. coli O157:H7 or other STEC must not provide personal care to persons in a health care facility while the disease is present in a communicable form without the approval of the Department or Health District. Two (2) fecal specimens negative for E. coli O157:H7 or other STEC are sufficient to remove this restriction. ( )

251. -- 259. (RESERVED).

260. EXTRAORDINARY OCCURRENCE OF ILLNESS, INCLUDING CLUSTERS.

01. Reporting Requirements. Cases, suspected cases, and clusters of extraordinary or unusual illness must be reported to the Department or Health District within one (1) working day by the diagnosing person. ( )

a. Extraordinary or unusual outbreaks include illnesses which may be a significant risk to the public, may involve a large number of persons, or are a newly described entity. ( )

b. Even in the absence of a defined etiologic agent or toxic substance, clusters of unexplained acute illness and early-stage disease symptoms must be reported to the Department or Health District within one (1) working day and investigated. ( )

02. Investigation. Each reported case of extraordinary occurrence of illness, including clusters, must be investigated to confirm the diagnosis, determine the extent of the outbreak, identify the source of infection or exposure, and determine whether there is a risk to the public warranting intervention by a public health agency. Evaluation and control measures will be undertaken in consultation with the Department and other appropriate agencies. The Department may elect to investigate by conducting special studies as outlined in Section 070 of these rules. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case. ( )

261. -- 269. (RESERVED).

270. FOOD POISONING, FOODBORNE ILLNESS, AND WATERBORNE ILLNESS.

01. Reporting Requirements. Each case or suspected case of food poisoning, foodborne illness, or waterborne illness must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of food poisoning, foodborne illness, or waterborne illness must be investigated to confirm the diagnosis, determine the extent of the outbreak, identify the source, and determine if actions need to be taken to prevent additional cases. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day of any reported case or suspected case. ( )

271. -- 279. (RESERVED).

280. GALACTOSEMIA.
Each case or suspected case of galactosemia must be reported to the Department or Health District within one (1) working day after diagnosis. ( )

281. -- 289. (RESERVED).

290. GIARDIASIS.

01. Reporting Requirements. Each case of giardiasis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of giardiasis must be investigated to determine if the person is employed as a food employee, provides personal care at a health care or day care facility, or is a child attending a day care facility. The investigation determines the water sources used by the person with giardiasis, the extent of the outbreak, and the most likely source of the infection. ( )

03. Restrictions - Day Care Facility. A person with diarrhea who is excreting Giardia lamblia must not attend day care while fecally incontinent or provide personal care to children in a day care facility while the disease is present in a communicable form or until therapy is completed. An asymptomatic person may provide these services or attend day care with specific approval of the Department or Health District. ( )

04. Restrictions - Food Service Facility. A symptomatic person who is excreting Giardia lamblia is restricted from working as a food employee under IDAPA 16.02.19, "The Idaho Food Code." ( )

05. Restrictions - Health Care Facility. A person with diarrhea who is excreting Giardia lamblia must not provide personal care to persons in a health care facility while the disease is present in a communicable form or until therapy is completed. An asymptomatic person may provide these services with specific approval of the Department or Health District. ( )

291. -- 299. (RESERVED).

300. HAEMOPHILUS INFLUENZAE INVASIVE DISEASE.

01. Reporting Requirements. Each case or suspected case of Haemophilus influenzae invasive disease, including meningitis, septicemia, bacteremia, epiglottitis, pneumonia, osteomyelitis and cellulitis, must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of Haemophilus influenzae invasive disease must be investigated to confirm the diagnosis, determine the extent of the outbreak, identify contacts, and determine the need for antimicrobial prophylaxis of close contacts. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of Haemophilus influenzae invasive disease. ( )

04. Restrictions - Day Care Facility. A person who is diagnosed with a disease caused by invasive Haemophilus influenzae must not work in an occupation providing personal care to children, or attend a day care facility as long as the disease is in a communicable form.
. ( )

05. Restrictions - School. A person who is diagnosed with a disease caused by invasive Haemophilus influenzae_must not work in any occupation where there is direct contact with students or attend a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

301. -- 309. (RESERVED).

310. HANTAVIRUS PULMONARY SYNDROME.

01. Reporting Requirements. Each case or suspected case of hantavirus pulmonary syndrome must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of hantavirus pulmonary syndrome must be investigated to confirm the diagnosis, determine environmental risk factors leading to the infection, and determine any other at-risk individuals. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day by telephone on any reported case or suspected case of hantavirus pulmonary syndrome. ( )

311. -- 319. (RESERVED).

320. HEMOLYTIC-UREMIC SYNDROME (HUS).

01. Reporting Requirements. Each case of HUS must be reported to the Department or Health District within one (1) working day. ( )

02. Investigation. Each case of HUS must be investigated to confirm the diagnosis, determine the etiologic agent including E. coli O157:H7, non-O157 Shiga-toxin producing E. coli, or other enteric pathogens, and determine the source of infection. ( )

321. -- 329. (RESERVED).

330. HEPATITIS A.

01. Reporting Requirements. Each case or suspected case of hepatitis A must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of hepatitis A must be investigated to confirm the diagnosis, identify contacts, determine the need for immune serum globulin (gamma globulin) or vaccine, and identify possible sources of the infection. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis A when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

04. Restrictions - Day Care Facility. A child who has hepatitis A must not attend a day care facility until the disease is no longer communicable as determined by a licensed physician, or unless an exemption is made by the Department or Health District. ( )

a. A person with hepatitis A must not work in any occupation in which personal care is provided to children in a day care facility while the disease is in a communicable form. ( )

b. The Department or Health District may withdraw this restriction when the illness is considered to no longer be in a communicable form. ( )

05. Exclusion - Food Service Facility.

a. A food employee with hepatitis A must be managed under IDAPA 16.02.19, "The Idaho Food Code." ( )

b. A specific test for recent hepatitis A infection (IgM antiHAV) must be performed by a licensed laboratory on all food employees suspected of having hepatitis A. ( )

06. Restrictions - Health Care Facility. A person with hepatitis A in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

a. A person with hepatitis A must not work in any occupation in which personal care is provided to persons who are in a health care or living in a residential care facility while the disease is in a communicable form. ( )

b. The Department or Health District may withdraw this restriction when the illness is considered to no longer be in a communicable form. ( )

07. Restrictions - Household Contacts. Any unvaccinated household member where there is a case of hepatitis A must not work in any of the occupations listed in Subsections 300.04 through 300.06 of this rule, unless an exemption is obtained from the Department or Health District. ( )

331. -- 339. (RESERVED).

340. HEPATITIS B.

01. Reporting Requirements. Each case or suspected case of hepatitis B must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of hepatitis B must be investigated to confirm the diagnosis, identify contacts and carriers, determine the need for prophylaxis with immune globulins, determine the need for hepatitis B vaccine, determine the exposure of any pregnant women, and identify possible sources of the infection. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis B when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

04. Carrier Status. The carrier status of a person diagnosed with hepatitis B will be determined six (6) months after the initial diagnosis is established. ( )

a. The carrier status will be determined by the presence of hepatitis B surface antigen (HBsAG) in blood obtained at least six (6) months after the initial diagnosis of hepatitis B.( )

b. The test for hepatitis B surface antigen (HBsAg) must be performed by a licensed laboratory. ( )

c. A person who is a carrier of hepatitis B must be reported to the Department or Health District by the physician at the time of determination for inclusion in the hepatitis B carrier registry. ( )

341. -- 349. (RESERVED).

350. HEPATITIS C.

01. Reporting Requirements. Each case of hepatitis C must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of hepatitis C must be investigated to confirm the diagnosis and identify possible sources of the infection. Hepatitis C may be confirmed by

presence of hepatitis C antibody or antigen. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis C when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

351. -- 359. (RESERVED).

360. HUMAN IMMUNODEFICIENCY VIRUS (HIV).

01. Reporting Requirements. Each case of HIV infection, including positive HIV laboratory tests for HIV antibody, HIV antigen (protein or nucleic acid), human immunodeficiency virus isolations, or other tests of infectiousness that indicate HIV infection, must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of HIV infection must be investigated to obtain specific clinical information, identify possible sources, risk factors, and contacts. Other manifestations of HIV infection as defined by the Centers for Disease Control and Prevention may be investigated. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for HIV when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

361. -- 369. (RESERVED).

370. HUMAN T-LYMPHOTROPIC VIRUS.

01. Reporting Requirements. Each case of HTLV infection must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of HTLV infection must be investigated to determine the source of infection and evaluate risk factors. ( )

371. -- 379. (RESERVED).

380. LEAD POISONING.

01. Reporting Requirements. Each case of lead poisoning determined by symptoms or a blood lead level of ten (10) micrograms or more per deciliter (10 ug/dL) of whole blood, must be reported to the Department or Health District within three (3) working days of the identification of the case. ( )

02. Investigation. Each reported case of lead poisoning or excess lead exposure must be investigated to determine the source, and whether actions need to be taken to prevent

additional cases. ( )

381. -- 389. (RESERVED).

390. LEGIONELLOSIS.

01. Reporting Requirements. Each case of legionellosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of legionellosis must be investigated to confirm the diagnosis and identify possible sources of the infection. When two (2) or more cases occur within thirty (30) days of each other, an investigation must be conducted to identify a common environmental source and identify ways to prevent further infections. ( )

391. -- 399. (RESERVED).

400. LEPROSY (HANSEN'S DISEASE).

01. Reporting Requirements. Each case of leprosy must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of leprosy must be investigated to confirm the diagnosis and to identify household or other close contacts. ( )

03. Restrictions - Examination of Contacts. All household members or close contacts of a new case must be examined by a licensed physician for signs of leprosy. Household members and close contacts and persons in remission must be registered with the Department and undergo periodic medical examinations every six (6) to twelve (12) months for five (5) years. ( )

401. -- 409. (RESERVED).

410. LEPTOSPIROSIS.

01. Reporting Requirements. Each case of leptospirosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of leptospirosis must be investigated to confirm the diagnosis and to identify possible sources of the infection. ( )

03. Handling of Report. Any identified or suspected source of infection reported to the Department is reported to the Idaho Department of Agriculture if animals are involved.( )

411. -- 419. (RESERVED).

420. LISTERIOSIS.

01. Reporting Requirements. Each case of listeriosis must be reported to the

Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of listeriosis must be investigated to confirm the diagnosis and to identify possible sources of the infection and extent of the outbreak. ( )

421. -- 429. (RESERVED).

430. LYME DISEASE.

01. Reporting Requirements. Each case of Lyme disease must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of Lyme disease must be investigated to confirm the diagnosis and to identify possible sources of the infection. ( )

03. Handling of Report. Any identified or suspected source of infection reported to the Department is reported to the Idaho Department of Agriculture if animals are involved.( )

431. -- 439. (RESERVED).

440. MALARIA.

01. Reporting Requirements. Each case of malaria must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of malaria must be investigated to determine the type and the source of the infection. If transmission may have occurred in Idaho, an entomologic investigation will be performed by the Department or Health District to determine the extent of mosquito activity, and to institute control measures if endemic transmission is determined. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for malaria when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

441. -- 449. (RESERVED).

450. MAPLE SYRUP URINE DISEASE.
Each case or suspected case of maple syrup urine disease must be reported to the Department or Health District within one (1) working day of identification. ( )

451. -- 459. (RESERVED).

460. MEASLES (RUBEOLA).

01. Reporting Requirements. Each case or suspected case of measles must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of measles must be investigated to confirm the diagnosis, determine the extent of the outbreak, identify the source of the infection, and to identify susceptible contacts. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of measles. ( )

04. Restrictions - Day Care Facility and School. ( )

a. A child diagnosed with measles must not attend a day care facility or school as long as the disease is in a communicable form. ( )

b. In the event of a case of measles in a day care or school, susceptible children must be excluded until adequate immunization is obtained, or the threat of further spread of the disease is contained, as provided in Sections 33-512(7) and 39-1118, Idaho Code. ( )

c. A person who is diagnosed as having measles must not work in any occupation in which there is direct contact with children, as long as the disease is in a communicable form. ( )

05. Restrictions - Health Care Facility. A person diagnosed with measles in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated by reference in Section 004 of these rules. ( )

461. -- 469. (RESERVED).

470. MENINGITIS, VIRAL OR ASEPTIC.
Each case of viral or aseptic meningitis must be reported to the Department or Health District within three (3) working days of identification. ( )

471. -- 47*4*. (RESERVED).

475. METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA).

01. Reporting Requirements*. Each case or suspected case of invasive methicillin-resistant Staphylococcus aureus (MRSA), defined as MRSA isolated from a normally sterile site, must be reported to the Department or Health District within three (3) working days of identification by the laboratory director.* *( )*

02. Investigation*. Any case of MRSA may be investigated to determine source and recommend measures to prevent spread.* *( )*

03. Restrictions - Day Care Facility*. A person who is diagnosed with MRSA infection must not work in an occupation providing personal care to children, or attend a day care facility, if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and* *( )*

a. *The lesion is on the hands, wrists, or exposed portions of the arms, and is not*

protected by an impermeable cover; or ( )

b. *The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage.* ( )

04. Restrictions - Food Service Facility*. A food employee diagnosed with MRSA infection must be managed under IDAPA 16.02.19, "The Idaho Food Code."* ( )

05. Restrictions - Health Care Facility*. A person who is diagnosed with MRSA infection must not provide personal care to persons in a health care facility if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and* ( )

a. *The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or* ( )

b. *The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage.* ( )

06. Restrictions - School*. A person who is diagnosed with MRSA infection must not work in an occupation where there is direct contact with students or attend a private, parochial, charter, or public school, if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and* ( )

a. *The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or* ( )

b. *The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage.* ( )

476. -- 479. (RESERVED).

480. MUMPS.

01. Reporting Requirements. Each case of mumps must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of mumps must be investigated to determine the immunization history or if the cause for an outbreak is unusual. ( )

03. Restrictions. A person with mumps must be restricted from day care, school, or work for nine (9) days after the onset of parotid swelling. ( )

481. -- 489. (RESERVED).

490. MYOCARDITIS, VIRAL.

01. Reporting Requirements. Each case of viral myocarditis must be reported to the

Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of viral myocarditis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection. ( )

491. -- 499. (RESERVED).

500. NEISSERIA GONORRHOEAE.

01. Reporting Requirements. Each case of Neisseria gonorrhoeae infection must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. A person diagnosed with urethral, cervical, oropharyngeal, or rectal gonorrhea is required to inform his sexual contacts or provide sufficient information to health officials in order to locate these contacts. The contacts must be advised of their exposure to a sexually transmitted infection and informed they should seek examination and treatment. ( )

03. Prophylaxis of Newborns. Prophylaxis against gonococcal ophthalmia neonatorum is described in IDAPA 16.02.12, "Rules Governing Procedures and Testing To Be Performed on Newborn Infants." ( )

04. Isolation - Health Care Facility. A person with gonococcal ophthalmia neonatorum in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

501. -- 509. (RESERVED).

510. NEISSERIA MENINGITIDIS INVASIVE DISEASE.

01. Reporting Requirements. Each case or suspected case of Neisseria meningitidis invasive disease, including meningitis and septicemia, must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of Neisseria meningitidis invasive disease must be investigated to confirm the diagnosis, to determine the extent of the outbreak, identify contacts, and determine the need for antimicrobial prophylaxis or immunization of close contacts. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of Neisseria meningitidis invasive disease. ( )

04. Restrictions - Day Care Facility. A person who is diagnosed with a disease caused by Neisseria meningitidis must not provide personal care to children, or attend a day care facility, as long as the disease is present in a communicable form. ( )

05. Restrictions - Health Care Facility. A person with Neisseria meningitidis in a

health care facility or residential care facility must be placed under respiratory isolation until twenty-four (24) hours after initiation of effective therapy. ( )

06. Restrictions - School. A person who is diagnosed with a disease caused by Neisseria meningitidis must not work in any occupation that involves direct contact with students, or attend a private, parochial, charter, or public school as long as the disease is present in a communicable form. ( )

511. -- 519. (RESERVED).

520. NOROVIRUS.

01. Reporting Requirements. Each case or suspected case of norovirus must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of norovirus must be investigated to confirm the diagnosis, determine the extent of the outbreak, and identify the source of the infection. ( )

03. Restrictions - Day Care Facility. A person excreting norovirus must not attend or provide personal care in a day care while symptomatic, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic, unless hygienic practices are insufficient. ( )

04. Exclusions - Food Service Facility. A person suspected or diagnosed with norovirus is excluded from working as a food employee while symptomatic, unless an exemption is made by the Department or Health District. This exclusion will be withdrawn once the person is asymptomatic, unless hygienic practices are insufficient. ( )

05. Restrictions - Health Care Facility. A person excreting norovirus must not provide personal care in a health care facility, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic, unless hygienic practices are insufficient. ( )

06. Restrictions - School. A person excreting norovirus must not attend or work in a private, parochial, charter, or public school while symptomatic, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic, unless hygienic practices are insufficient. ( )

521. -- 529. (RESERVED).

530. PERTUSSIS.

01. Reporting Requirements. Each case or suspected case of pertussis must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of pertussis must be investigated to confirm the diagnosis, determine the extent of the outbreak, identify susceptible contacts, and identify the source of the infection. ( )

03. Restrictions - Day Care Facility. A person who is diagnosed with pertussis must not work in any occupation in which there is direct contact with children, or attend a day care facility, as long as the disease is in a communicable form. ( )

04. Restrictions - Health Care Facility. A person who is diagnosed with pertussis must not work in any occupation in which there is direct contact with other persons in a health care facility as long as the disease is in a communicable form. ( )

05. Restrictions - School. A person diagnosed with pertussis must not attend or work in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

531. -- 539. (RESERVED).

540. PHENYLKETONURIA.
Each case or suspected case of phenylketonuria must be reported to the Department or Health District within one (1) working day of identification. ( )

541. -- 549. (RESERVED).

550. PLAGUE.

01. Reporting Requirements. Each case or suspected case of plague must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of plague must be investigated to confirm the diagnosis, determine the source, the extent of the outbreak, and whether there has been person-to-person transmission. ( )

03. Handling of Report. Each case of plague reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. ( )

04. Restrictions - Health Care Facility. ( )

a. A person with or suspected of having pneumonic plague in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

b. A person with or suspected of having bubonic plague in health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

05. Prophylaxis of Contacts. Household members and face-to-face contacts of a person with pneumonic plague must be placed on chemoprophylaxis and placed under surveillance for seven (7) days. A person who refuses chemoprophylaxis must be maintained under droplet precautions with careful surveillance for seven (7) days. ( )

551. -- 559. (RESERVED).

560. PNEUMOCOCCAL INVASIVE DISEASE IN CHILDREN LESS THAN EIGHTEEN YEARS OF AGE.

01. Reporting Requirements. Each case of pneumococcal invasive disease in children under eighteen (18) years of age including meningitis, septicemia, bacteremia, and pneumonia, must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of pneumococcal invasive disease in children must be investigated to confirm the diagnosis and determine relevant vaccine history. ( )

03. Restrictions - Day Care Facility. A person who is diagnosed with pneumococcal invasive disease must not attend day care or work in any occupation in which there is direct contact with children in a day care facility as long as the disease is in a communicable form. ( )

04. Restrictions - School. A person diagnosed with pneumococcal invasive disease must not attend or work in any occupation in which there is direct contact with children in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

561. -- 569. (RESERVED).

570. PNEUMOCYSTIS PNEUMONIA (PCP).

01. Reporting Requirements. Each case of Pneumocystis pneumonia (PCP) must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of Pneumocystis pneumonia (PCP) must be investigated to confirm the diagnosis, and to determine the underlying cause of any immune deficiency which may have contributed to the disease. When the underlying cause is an HIV infection, it must be reported as described in Section 360 of these rules. ( )

571. -- 579. (RESERVED).

580. POLIOMYELITIS.

01. Reporting Requirements. Each case or suspected case of poliomyelitis infection must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of poliomyelitis infection must be investigated to confirm the diagnosis, to determine whether the case is polio vaccine associated or wild virus associated, to determine the extent of the outbreak, whether there has been person-to-person

transmission, and to identify susceptible contacts, carriers, and source of the infection. ( )

03. Immunization of Personal Contacts. The immunization status of personal contacts is determined and susceptible contacts are offered immunization. ( )

581. -- 589. (RESERVED).

590. PSITTACOSIS.

01. Reporting Requirements. Each case of psittacosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case must be investigated to confirm the diagnosis, determine the extent of the outbreak, and identify possible sources of the infection. ( )

03. Handling of Report. Any identified sources or suspected sources of infection must be reported to the Department which will notify the Idaho Department of Agriculture if birds or other animals are involved. ( )

591. -- 599. (RESERVED).

600. Q FEVER.

01. Reporting Requirements. Each case or suspected case of Q fever must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of Q fever must be investigated to confirm the diagnosis, determine the extent of the outbreak, and identify the source of the infection. ( )

03. Handling of Report. Any identified or suspected sources of infection must be reported to the Department which will notify the Idaho Department of Agriculture if animals are involved. ( )

601. -- 609. (RESERVED).

610. RABIES -- HUMAN AND ANIMAL.

01. Reporting Requirements. ( )

a. Each case or suspected case of rabies in humans must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

b. Each case or suspected case of rabies in animals must be reported to the Department or Health District and the Idaho Department of Agriculture within one (1) working day of identification. ( )

c. Each instance of rabies post-exposure prophylaxis (rPEP) series initiation must be reported to the Department or Health District within one (1) working day. ( )

02. Investigation. ( )

a. Each reported case or suspected case of rabies in humans must be investigated to confirm the diagnosis, identify the source and other persons or animals that may have been exposed to the source, and identify persons who may need to undergo prophylaxis with rabies immune globulin and rabies vaccine. ( )

b. Each reported rPEP series initiation must be investigated to determine if additional individuals require rPEP and identify the source of possible exposure. ( )

03. Handling of Report. The Health District must notify the Department and the Idaho Department of Agriculture within one (1) working day of each reported case of this disease. ( )

04. Management of Exposure to Rabies. In the event that a human or animal case of rabies occurs, any designated representative of the Department, Health District, or Idaho Department of Agriculture, will establish such isolation and quarantine of animals as deemed necessary to protect the public health. ( )

a. The handling of a rabies-susceptible animal that has bitten a person must be as follows: ( )

i. Any livestock which has bitten a person must be managed by the Idaho Department of Agriculture. ( )

ii. Any healthy domestic dog, cat, or ferret that has bitten a person must be observed for ten (10) days following the bite under the supervision of a licensed veterinarian or other person designated by the Idaho Department of Agriculture, Health District, or the Department. Such observation must be within an enclosure or with restraints deemed adequate to prevent contact with any member of the public or other animals. ( )

iii. It is the animal owner's responsibility to carry out the quarantine of the biting animal and to follow instructions provided for the quarantine of the animal. ( )

iv. Any domestic dog, cat, or ferret that has not been vaccinated against rabies by a licensed veterinarian and can not be quarantined, must be destroyed by a means other than shooting in the head. The head must be submitted to an approved laboratory for rabies analysis. ( )

v. Susceptible animals other than domestic dogs, cats, ferrets, or livestock must be destroyed and the head submitted to an approved laboratory for rabies analysis, unless an exemption is given by the Department or Health District. ( )

vi. No person will destroy, or allow to be destroyed, the head of a rabies-susceptible animal that has bitten a person without authorization from the Department or Health District. ( )

b. The handling of a rabies-susceptible animal that has not bitten a person, but has within the past one hundred eighty (180) days been bitten, mouthed, mauled by, or closely confined in the same premises with a known rabid animal must be as follows: ( )

i. Any domestic dog, cat, ferret, or livestock which has not been vaccinated as recommended by the American Veterinary Medical Association, must be placed in quarantine for a period of six (6) months under the observation of a licensed veterinarian or a person designated by the Idaho Department of Agriculture, Health District, or the Department and vaccinated according to the Rabies Compendium. An animal with current vaccinations, including livestock, should be revaccinated immediately with an appropriate rabies vaccine and quarantined for forty-five (45) days. These provisions apply only to animals for which an approved rabies vaccine is available. ( )

ii. The quarantine of such animal must be within an enclosure deemed adequate by a person designated by the Idaho Department of Agriculture, the Department, or Health District to prevent contact with any person or rabies-susceptible animal. ( )

iii. The owner of the animal is financially responsible for the cost of isolating and quarantining the animal and for specimen collection and testing. ( )

iv. Destruction of such animal is permitted as an alternative to quarantine. ( )

c. Any rabies-susceptible animal other than domestic dogs, cats, ferrets, or livestock that are suspected of having rabies, or which have been in close contact with an animal known to be rabid, must be destroyed. The animal must be tested by an approved laboratory for rabies if a person has been bitten or has had direct contact with the animal which might result in the person becoming infected. ( )

05. City or County Authority. Nothing in these rules is intended or will be construed to limit the power of any city or county in its authority to enact more stringent requirements to prevent the transmission of rabies. ( )

611. -- 619. (RESERVED).

620. RELAPSING FEVER, TICK-BORNE AND LOUSE-BORNE.

01. Reporting Requirements. Each case of tick-borne or louse-borne relapsing fever must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of tick-borne or louse-borne relapsing fever must be investigated to confirm the diagnosis, determine the extent and source of the outbreak, and whether transmission was from lice or ticks. ( )

621. -- 629. (RESERVED).

630. RESPIRATORY SYNCYTIAL VIRUS (RSV).
A laboratory director must report each detection of respiratory syncytial virus (RSV) infection to

the Department or Health District within one (1) working day of identification. ( )

631. -- 639. (RESERVED).

640. REYE SYNDROME.

01. Reporting Requirements. Each case of Reye syndrome must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of Reye syndrome must be investigated to obtain specific clinical information and to learn more about the etiology, risk factors, and means of preventing the syndrome. ( )

641. -- 649. (RESERVED).

650. ROCKY MOUNTAIN SPOTTED FEVER.

01. Reporting Requirements. Each case of Rocky Mountain spotted fever must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of Rocky Mountain spotted fever must be investigated to confirm the diagnosis, identify the source of infection, and determine if control measures should be initiated. ( )

651. -- 659. (RESERVED).

660. RUBELLA - INCLUDING CONGENITAL RUBELLA SYNDROME.

01. Reporting Requirements. Each case or suspected case of rubella or congenital rubella syndrome must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of rubella or congenital rubella syndrome must be investigated to confirm the diagnosis, determine the extent of the outbreak, identify any contacts who are susceptible and pregnant, and document the presence of the congenital rubella syndrome. ( )

03. Restrictions - Day Care Facility. A person diagnosed with rubella must not attend, be present, or work in any occupation in which there is close contact with children in a day care facility as long as the disease is in a communicable form. ( )

04. Restrictions - Health Care Facility. A person diagnosed with rubella must not work in any occupation in which there is close contact with other persons in a health care facility as long as the disease is in a communicable form. ( )

05. Restrictions - Schools. A person diagnosed with rubella must not attend, be present, or work in any occupation in which there is close contact with children or other persons

in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

06. Restrictions - Personal Contact. A person diagnosed with rubella must not work in occupations in which there is close contact with women likely to be pregnant as long as the disease is in a communicable form. ( )

661. -- 669. (RESERVED).

670. SALMONELLOSIS - INCLUDING TYPHOID FEVER.

01. Reporting Requirements. Each case or suspected case of salmonellosis or typhoid fever must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of salmonellosis or typhoid fever must be investigated to confirm the diagnosis, to determine the extent of the outbreak, and to identify contacts, carriers, and the source of contamination. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any suspected or reported case. ( )

04. Restrictions - Chronic Carrier. Chronic carriers, which are those who excrete Salmonella for more than one (1) year after onset, are restricted from working as food employees. Chronic carriers must not work in any occupation in which they provide personal care to children in day care facilities, or to persons who are confined to health care facilities or residential care facilities, until Salmonella is not identified by a licensed laboratory in any of three (3) successive approved fecal specimens collected at least seventy-two (72) hours apart. ( )

05. Restrictions - Non-Typhi Salmonella. ( )

a. A fecally incontinent person excreting non-Typhi Salmonella must not attend a day care facility. ( )

b. A person excreting non-Typhi Salmonella must not work in any occupation in which they provide personal care to children in a day care facility or provide personal care to persons confined to a health care facility, unless an exemption is obtained from the Department or Health District. ( )

c. A symptomatic food employee excreting non-Typhi Salmonella must be managed under the IDAPA 16.02.19, “The Idaho Food Code.” ( )

d. If hygienic practices are insufficient, before a person can attend or work in a day care facility or a health care facility, or work as a food employee, he must provide two (2) approved fecal specimens which are negative for Salmonella upon testing by a licensed laboratory, collected not less than twenty-four (24) hours apart and forty-eight (48) hours after the last dose of antimicrobials. ( )

e. The Department may withdraw this restriction on a case of non-Typhi Salmonella provided that the person is asymptomatic. ( )

f. Any member of a household in which there is a case of non-Typhi salmonellosis must not work as a food employee until he produces at least one (1) negative fecal specimen for *Salmonella* upon testing by a licensed laboratory. ( )

06. Restrictions - Salmonella Typhi.

a. Any person with typhoid fever will remain subject to the supervision of the Department until Salmonella Typhi is not isolated by a licensed laboratory from three (3) successive approved fecal specimens. These specimens are to be collected at least twenty-four (24) hours apart and not earlier than one (1) month after onset. ( )

b. A food employee excreting Salmonella Typhi must be managed under IDAPA 16.02.19, "The Idaho Food Code." ( )

c. Any member of a household in which there is a case of Salmonella Typhi must not work in the occupations described in Subsection *670.05.d.* of this rule until at least two (2) fecal specimens approved fecal specimens are negative for Salmonella upon testing by a licensed laboratory. *( )*

d. All chronic carriers of Salmonella Typhi must abide by a written agreement called a typhoid fever carrier agreement. This agreement is between the chronic carrier and the Department or Health District. Failure of the carrier to abide by the carrier agreement may cause the carrier to be isolated under Section 065 of these rules. The carrier agreement requires: ( )

i. The carrier cannot work as a food employee; ( )

ii. Specimens must be furnished for examination in a manner described by the Department or Health District*; and* *( )*

iii. The Department or Health District must be notified immediately of any change of address, occupation, and cases of illness suggestive of typhoid fever in his family or among immediate associates. ( )

e. Chronic carriers of typhoid fever may be released from carrier status when Salmonella Typhi is not identified by a licensed laboratory in any of six (6) consecutive approved fecal and urine specimens collected at least one (1) month apart. ( )

671. -- 679. (RESERVED).

680. SEVERE ACUTE RESPIRATORY SYNDROME (SARS).

01. Reporting Requirements. Each case or suspected case of severe acute respiratory syndrome (SARS) must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of SARS must be investigated to confirm the diagnosis, review the travel and other exposure history, identify other persons potentially at risk, and identify the most likely source of the infection. ( )

03. Isolation. Recommendations for appropriate isolation of the suspected or confirmed case will be made by the Department or Health District. ( )

681. -- 689. (RESERVED).

690. SEVERE REACTION TO ANY IMMUNIZATION.

01. Reporting Requirements. Each case or suspected case of a severe reaction to any immunization must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of severe reaction to any immunization must be investigated to confirm and document the circumstances relating to the reported reaction to the immunization. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case. ( )

691. -- 699. (RESERVED).

700. SHIGELLOSIS.

01. Reporting Requirements. Each case or suspected case of shigellosis must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of shigellosis must be investigated to confirm the diagnosis and determine the extent of the outbreak. An attempt must be made to identify contacts, carriers, and the source of the infection. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any suspected or reported case. ( )

04. Restrictions - Day Care Facility. ( )

a. A person excreting Shigella must not attend a day care facility while fecally incontinent. ( )

b. A person excreting Shigella must not work in any occupation in which he provides personal care to children in a day care facility while the disease is present in a communicable form, unless an exemption is obtained from the Department or Health District. During an outbreak in a day care facility, a cohort system may be approved. ( )

c. The Department or Health District may withdraw the day care restriction provided that two (2) approved fecal specimens collected at least twenty-four (24) hours apart are negative

for Shigella upon testing by a licensed laboratory. ( )

05. Exclusions - Food Service Facility.

a. A food employee excreting Shigella must be managed under IDAPA 16.02.19, "The Idaho Food Code." ( )

b. The Department or Health District may withdraw the food service restriction provided that two (2) approved fecal specimens collected at least twenty-four (24) hours apart are negative for Shigella upon testing by a licensed laboratory. ( )

06. Restrictions - Health Care Facility. A person excreting Shigella must not work in any occupation in which he provides personal care to persons who are confined to a health care facility while the disease is present in a communicable form, unless an exemption is obtained from the Department or Health District. During an outbreak in a facility, a cohort system may be approved. ( )

07. Restrictions - Household Contacts. No member of a household, in which there is a case of shigellosis, may work in any occupations in Subsections 700.04 through 700.06 of this rule, unless the Department or Health District approves and at least one (1) fecal specimen is negative for Shigella upon testing by a licensed laboratory. ( )

701. -- 709. (RESERVED).

710. SMALLPOX.

01. Reporting Requirements. Each case or suspected case of smallpox must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of smallpox must be investigated promptly to confirm the diagnosis, determine the extent of the outbreak, and identify the source of the infection and susceptible contacts. ( )

03. Restrictions - Day Care Facility. ( )

a. A person diagnosed with smallpox must not attend a day care facility as long as the disease is in a communicable form. ( )

b. In the event of an outbreak, the Department or Health District may exclude susceptible children and employees from day care facilities where a case has been identified until adequate immunization is obtained or the threat of further spread is contained. ( )

04. Restrictions - Health Care Facility. A person diagnosed or suspected of having smallpox in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

05. Restrictions - Public Gatherings. A person diagnosed with smallpox must not

attend public gatherings as long as the disease is in a communicable form. ( )

06. Restrictions - School. ( )

a. A person diagnosed with smallpox, regardless of age, must not attend a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

b. In the event of an outbreak, the Department or Health District may exclude susceptible children and employees from schools where a case has been identified until adequate immunization is obtained or the threat of further spread is contained under Section 33-512(7), Idaho Code. ( )

07. Restrictions - Working. A person diagnosed with smallpox must not work in any occupation as long as the disease is in a communicable form. ( )

711. -- 719. (RESERVED).

720. STREPTOCOCCUS PYOGENES (GROUP A STREP) INFECTIONS WHICH ARE INVASIVE OR RESULT IN RHEUMATIC FEVER.

01. Reporting Requirements. Each case of Streptococcus pyogenes (group A Strep) infection which is invasive or results in rheumatic fever must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of Streptococcus pyogenes (group A Strep) infection must be investigated to confirm the diagnosis, to determine if the infection is part of an outbreak, and to identify the source of the infection. ( )

03. Restrictions - Day Care Facility. An infected person must not attend or work in a day care until twenty-four (24) hours has elapsed after treatment is initiated or until he is no longer infectious as determined by a physician, the Department or Health District. ( )

04. Restrictions - Health Care Facility. An infected person must not work in a health care facility until twenty-four (24) hours has elapsed after treatment is initiated or until he is no longer infectious as determined by a physician, the Department or Health District. ( )

05. Restrictions - School. **An** infected person must not attend or work in a private, parochial, charter, or public school until twenty-four (24) hours has elapsed after treatment is initiated or until the patient is no longer infectious as determined by a physician, the Department or Health District. ( )

721. -- 729. (RESERVED).

730. SYPHILIS.

01. Reporting Requirements. Each case or suspected case of syphilis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of primary, secondary, or early latent syphilis must be investigated by the Department or Health District. Each person diagnosed with infectious syphilis is required to inform his sexual contacts that they may have been exposed to a sexually transmitted infection, or provide sufficient information to public health officials so they may locate contacts and assure that each is offered prompt diagnosis and treatment under Section 39-605, Idaho Code. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for syphilis when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

731. -- 739. (RESERVED).

740. TETANUS.

01. Reporting Requirements. Each case of tetanus must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of tetanus must be investigated to confirm the diagnosis and to determine the immunization status of the case. ( )

741. -- 749. (RESERVED).

750. TOXIC SHOCK SYNDROME.

01. Reporting Requirements. Each case of toxic shock syndrome must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of toxic shock syndrome must be investigated to obtain specific clinical information on the syndrome and to determine the etiology, risk factors, and means of preventing the syndrome. ( )

751. -- 759. (RESERVED).

760. TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES (TSE), INCLUDING CREUTZFELDT-JAKOB DISEASE (CJD) AND VARIANT CJD (VCJD).

01. Reporting Requirements. Each case of transmissible spongiform encephalopathy (TSE), including Creutzfeldt-Jakob disease (CJD) and variant CJD (vCJD) must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of transmissible spongiform encephalopathy (TSE) must be investigated to determine the cause and confirm the diagnosis. ( )

03. Autopsy. The state epidemiologist may order an autopsy for suspected CJD or vCJD cases as per Section 39-277, Idaho Code. ( )

761. -- 769. (RESERVED).

770. TRICHINOSIS.

01. Reporting Requirements. Each case of trichinosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of trichinosis must be investigated to confirm the diagnosis, determine the extent of the outbreak, and identify the source of the infection.( )

03. Handling of Report. The Department will notify the Idaho Department of Agriculture and other regulatory agencies as applicable. ( )

771. -- 779. (RESERVED).

780. TUBERCULOSIS.

01. Reporting Requirements. Each case of tuberculosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of tuberculosis must be investigated to confirm the diagnosis, identify contacts, associated cases, and the source of the infection. ( )

03. Active Pulmonary Tuberculosis - Definition*. Tuberculosis disease of the lungs, determined by a physician to be potentially contagious by clinical or bacteriological evidence or by evidence of the spread of the disease to others. Tuberculosis is considered active until cured.* *( )*

04. Cure of Tuberculosis - Definition*. The completion of a course of antituberculosis treatment.* *( )*

05. Restrictions - Day Care Facility. A person with *active* pulmonary tuberculosis must not attend or work in any occupation in which he has direct contact or provides personal care to children in a day care facility, until he is determined to be noninfectious by a licensed physician, the Department or Health District. *( )*

06. Restrictions - Health Care Facility. ( )

a. A person suspected to have pulmonary tuberculosis in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules, until the diagnosis of *active* pulmonary tuberculosis is excluded by a licensed physician. ( )

b. A person with active pulmonary tuberculosis in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules, until he is determined to be noninfectious by a licensed physician, the infection control committee of the facility, or the Department. ( )

c. A person with *active* pulmonary tuberculosis must not work in any occupation in which he has direct contact or provides personal care to persons confined to a health care or residential care facility, until he is determined to be noninfectious by a licensed physician, infection control committee of the facility, or the Department. *( )*

d. In the event that *active pulmonary* tuberculosis is diagnosed in an employee, patient, or resident, the health care facility must conduct an investigation to identify contacts. The Department or Health District may assist in the investigation. *( )*

0*7*. Restrictions - School. A person with *active* pulmonary tuberculosis must not attend or work in any occupation in which he has direct contact with students in a private, parochial, charter, or public school until he is determined to be noninfectious by a licensed physician, the Department or Health District. *( )*

0*8*. Restrictions - Household Contacts. Any member of a household, in which there is a case of *active pulmonary* tuberculosis, must not attend or work in any occupation in which he provides direct supervision of students in a school, personal care to children in a day care facility *or* persons confined to a health care facility, or works in a food service facility, until he has been determined to be *noninfectious by a licensed physician, the Department, or Health District.* *( )*

781. -- 789. (RESERVED).

790. TULAREMIA.

01. Reporting Requirements. Each case or suspected case of tularemia must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of tularemia must be investigated to confirm the diagnosis and to identify the source of the infection. ( )

03. Handling of Report. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of the infection. ( )

791. -- 799. (RESERVED).

800. WEST NILE VIRUS (WNV).

01. Reporting Requirements. Each case or suspected case of West Nile virus (WNV) infection must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of WNV infection must be investigated to confirm the diagnosis, review any travel history, review any blood donations, and identify the most likely source of infection including exposure to vectors, blood transfusion, or organ receipt. ( )

801. -- 809. (RESERVED).

810. YERSINIOSIS, OTHER THAN PLAGUE.

01. Reporting Requirements. Each case of yersiniosis, other than plague, must be reported to the Department or Health District within three (3) working days of identification. Plague must be reported immediately as described in Section 550 of these rules. ( )

02. Investigation. Each reported case of yersiniosis must be investigated to confirm the diagnosis, identify carriers, and the source of the infection. ( )

03. Restrictions - Food Service Facility. A symptomatic person excreting Yersinia is restricted from working as a food employee under IDAPA 16.02.19, "The Idaho Food Code." ( )

811. -- 949. (RESERVED).

DELEGATION OF POWERS AND DUTIES

(SECTIONS 950 - 999)

950. DELEGATION OF POWERS AND DUTIES.
The Director has the authority to delegate to the Health Districts any of the powers and duties created by these rules under Section 39-414(2), Idaho Code. Any delegation authority will be in writing and signed by both the Director and the Health District Board. *( )*

951. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.15 - IMMUNIZATION REQUIREMENTS FOR IDAHO SCHOOL CHILDREN

DOCKET NO. 16-0215-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 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.

In order to protect school children from the spread of certain diseases, the state requires that children be immunized before they enter school. These rules provide clarification of the immunization requirements for school children. 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 word "and" was changed to "or" for clarification of the types of doses that meet immunization requirements in Section 100. The complete text of the proposed rules published in the October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 368 through 371.

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. This rulemaking has no fiscal impact to the state general fund.

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

DATED this 26th day of October, 2007.

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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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0215-0701***
Immunization Requirements for Idaho School Children ***PENDING RULE***

THE FOLLOWING NOTICE 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 October 17, 2007.

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:

In order to protect school children from the spread of certain diseases, the Department requires that children be immunized before they enter school. The current rule detailing immunization requirements for school children does not specify that the 5th dose of diphtheria, tetanus and pertussis (DTaP) and the 2nd dose of measles, mumps and rubella (MMR) are only for children entering kindergarten during or after the 2005-2006 school year as originally intended. The rule is being amended to make this update.

The rule is also being re-ordered to place the exemptions in closer proximity to the immunization requirements for ease of use. The pertussis requirement is being separated from the diphtheria and tetanus requirement due to the current vaccine formulations which sometimes do not include pertussis. The definitions are also being amended for clarity.

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.

This rulemaking has no anticipated fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rules are being amended for clarity only.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dieuwke Spencer at (208) 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 October 24,

2007.

DATED this 20th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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.*~~ Admission to a public, private or parochial school is: ~~*(4-6-05)*~~( )

a. Registration of a child before attendance; or ( )

b. Re-entry of a child after withdrawing from previous enrollment. ( )

03. Child. A minor who is enrolled in kindergarten through grade twelve (12) in any Idaho public, private, or parochial school. (3-30-07)

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~~ ~~i~~Immunizations~~,~~ listed in Subsections 100.01 through 100.04 of ~~these~~ this rule~~s~~, are required of children upon admission to kindergarten through grade twelve (12) of any Idaho public, private, or parochial school. Immunizations ~~will be recognized if~~ must be administered according to the "General Recommendations on Immunizations" established by the ACIP or their equivalent. These recommendations are available from the Department as provided in Section 004 of these rules. Exemptions from these immunization requirements are provided in Section 110 of these rules. ~~(3-30-07)~~(____)

01. Measles, Mumps and Rubella (MMR). (____)

a. A child born after September 1, 1999, is required to have any combination of ~~T~~two (2) doses of ~~Measles, Mumps and Rubella (MMR) or Measles, Mumps, Rubella and Varicella (MMRV)~~ the vaccines ~~administered to the child according to ACIP recommendations for children on or after the beginning of the 2005 school term~~ listed in Subsections 100.01.c. and 100.01.d. of this rule. ~~(3-30-07)~~(____)

b. A child born on or before September 1, 1999, is required to have one (1) dose of either of the vaccines listed in Subsections 100.01.c. and 100.01.d. of this rule. (____)

c. Measles, Mumps, and Rubella (MMR); *or* (____)

d. Measles, Mumps, Rubella and Varicella (MMRV). (____)

02. Diphtheria~~,~~ and Tetanus~~, and Pertussis~~. (____)

a. A child born after September 1, 1999, is required to have ~~A~~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~~ listed in Subsections 100.02.c. through 100.02.g. of this rule. If the fourth dose was administered on or after the child's fourth birthday, the fifth dose is not needed. ~~The approved combinations are:~~ ~~(3-30-07)~~(____)

b. A child born on or before September 1, 1999, is required to have any combination of four (4) doses, of the vaccines listed in Subsections 100.02.c. through 100.02.g. of this rule. ( )

~~a~~**c.** Diphtheria, Tetanus, and acellular Pertussis (DTaP - Pediatric); (3-30-07)

~~b~~**d.** Diphtheria, Tetanus and Pertussis (DTP); (3-30-07)

~~c~~**e.** Tetanus, Diphtheria and acellular Pertussis (Tdap - Adolescent); (3-30-07)

~~d~~**f.** Diphtheria, Tetanus (DT - Pediatric); ~~*and*~~ *or* ~~*(3-30-07)*~~( )

~~e~~**g.** Tetanus, Diphtheria (Td - Adolescent). (3-30-07)

03. Pertussis. ( )

a. A child born after September 1, 1999, is required to have any combination of five (5) doses of the vaccines listed in Subsections 100.03.c. through 100.03.e. of this rule. If the fourth dose was administered on or after the child's fourth birthday, the fifth dose is not needed. ( )

b. A child born on or before September 1, 1999, is required to have any combination of four (4) doses of the vaccines listed in Subsection 100.03.c. through 100.03.e. of this rule. ( )

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

d. Diphtheria, Tetanus and Pertussis (DTP); *or* ( )

e. Tetanus, Diphtheria and acellular Pertussis (Tdap - Adolescent). ( )

0~~3~~4. Polio. A child is required to have ~~T~~three (3) doses of Polio vaccine~~*, unless fewer doses are medically recommended. See Section 110 of these rules for exemptions to the immunization requirements*~~. ~~*(3-30-07)*~~( )

0~~4~~5. Hepatitis B. A child born after November 22, 1991, is required to have ~~T~~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.*~~ ~~*(3-30-07)*~~( )

06. Summary of Immunization Requirements. ( )

TABLE 100.06 SUMMARY OF IMMUNIZATION REQUIREMENTS		
Immunization Requirement*	**Child born after September 1, 1999**	**Child born on or before September 1, 1999**
Measles, Mumps, and Rubella (MMR)	2 doses	1 dose

TABLE 100.06 SUMMARY OF IMMUNIZATION REQUIREMENTS		
Immunization Requirement*	**Child born after September 1, 1999**	**Child born on or before September 1, 1999**
Diphtheria, Tetanus	5 doses	4 doses
Pertussis	5 doses	4 doses
Polio	3 doses	3 doses
Hepatitis B	3 doses	3 doses**

* Exemptions for immunization requirements are found in Section 110 of these rules.
** Hepatitis B - Three (3) doses unless child was born on or before November 22, 1991.
(____)

(BREAK IN CONTINUITY OF SECTIONS)

150. ENFORCEMENT OF IMMUNIZATION REQUIREMENT.

01. Noncompliance. Any child not in compliance with this chapter upon admission to any Idaho public, private or parochial school, will be denied attendance by school authorities, unless the child is exempt from these immunization requirements as provided in Section 110 of these rules. ~~*(3-30-07)*~~(____)

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

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.19 - FOOD SAFETY AND SANITATION STANDARDS FOR FOOD ESTABLISHMENTS (THE IDAHO FOOD CODE)

DOCKET NO. 16-0219-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 39-1603, Idaho Code.

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

To help protect the public against food-borne illnesses, the Department is amending the Idaho Food Code. The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the September 5, 2007, Idaho Administrative Bulletin, Vol. 07-9, pages 142 through 144.

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. This rulemaking has no fiscal impact to the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule contact Patrick Guzzle at (208) 334-5938.

DATED this 15th day of October, 2007.

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@dhw.idaho.gov e-mail

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0219-0701***
Food Safety and Sanitation Standards (The Idaho Food Code) ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221, Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-1603, Idaho Code.

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

Tuesday, September 18, 2007	**Wednesday, September 19, 2007**	**Thursday, September 20, 2007**
2:00 p.m.	**2:00 p.m.**	**2:00 p.m.**
Ameritel Inn	**Ameritel Inn-Spectrum**	**Ameritel Inn**
Coeur d'Alene West Conf. Rm.	**Robie Creek Conf. Rm.**	**Pebble Creek Conf. Rm.**
333 W. Ironwood Dr.	**7499 W. Overland Rd.**	**1440 Bench Road**
Coeur d'Alene, ID 83814	**Boise, ID 83709**	**Pocatello, ID 83201**
Phone: (208) 665-9000	**Phone: (208) 323-2500**	**Phone: (208) 234-7500**

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

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principle issues involved:

To help protect the public against food-borne illnesses, the Department of Health and Welfare have rules governing food safety and sanitation standards known as "The Idaho Food Code." These rules are being amended for the following reasons.

1. **Vendors at farmers' or community markets who sell prepared foods are required to meet these food safety standards. To make the rules easier to understand and to improve the consistency of how the rules are applied to these types of vendors throughout the state, a definition for an "intermittent food establishment" is be being added to clarify farmers' or community markets.**

2. **As new diseases or illnesses become known, the Centers for Disease Control and Preventions (CDC) determines which ones need to be controlled to prevent the spread of the disease. CDC has determined that Norovirus is the most common cause of food-borne outbreaks nationwide. The employee health section of these rules is being amended to add safety standards and precautions for the disease Norovirus.**

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.

This rulemaking has no fiscal impact to the state general fund for this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted. The Notice of Negotiated Rulemaking was published in the June 6, 2007, Idaho Administrative Bulletin, Vol. 07-6, page 64. The negotiated meetings were held for the issue of vendors at farmers' or community markets. The changes being made in this docket for Norovirus were not negotiated.

ASSISTANCE ON TECHNICAL QUESTIONS AND OBTAINING COPIES: For assistance on technical questions concerning this proposed rulemaking contact Patrick Guzzle at (208) 334-5938.

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 26, 2007.

DATED this 27th day of July, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

110. DEFINITIONS AND ABBREVIATIONS -- A THROUGH K.
The definitions defined in this section are modifications or additions to the definitions given in the 2001 Food Code. (4-6-05)

01. Agricultural Market. Any fixed or mobile retail food establishment engaged in the sale of raw or fresh fruits, vegetables and nuts in the shell. It may also include the sale of factory-sealed non-potentially hazardous foods. (4-6-05)

02. Board. The State of Idaho Board of Health and Welfare as established in Section 56-1005, Idaho Code. (4-6-05)

03. Consent Order. A consent order is an enforceable agreement between the regulatory authority and the license holder to correct violations that caused the actions taken by the regulatory authority. (4-6-05)

04. Department. The Idaho Department of Health and Welfare as established in Section 56-1002, Idaho Code.' (4-6-05)

05. Director. The Director of the Idaho Department of Health and Welfare as established in Section 56-1003, Idaho Code. (4-6-05)

06. Embargo. An action taken by the regulatory authority that places a food product

or equipment used in food production on hold until a determination is made on the product's safety. (4-6-05)

07. Enforcement Inspection. An inspection conducted by the regulatory authority when compliance with these rules by a food establishment is lacking and violations remain uncorrected after the first follow-up inspection to a routine inspection. (4-6-05)

08. Food Establishment. Modifications to Section 1-201.10(36) by deleting Section 1-201.10(36)(c)(iii) amends the definition of food establishment. (4-6-05)

09. Food Processing Plant. Modification to Section 1-201.10(37) by deleting Section 1-201.10(37)(b) amends the definition of food processing plant. (4-6-05)

10. High-Risk Food Establishment. A high-risk food establishment does the following operations: (4-6-05)

a. Extensive handling of raw ingredients; (4-6-05)

b. Preparation processes that include the cooking, cooling and reheating of potentially hazardous foods. (4-6-05)

c. A variety of processes requiring hot and cold holding of potentially hazardous food. (4-6-05)

11. Intermittent Food Establishment. An intermittent food establishment is one that operates for a period of time, not to exceed three (3) days per week, at a single, specified location in conjunction with a recurring event. Examples of a recurring event may be a farmers' or community market, or a holiday market. ( )

(BREAK IN CONTINUITY OF SECTIONS)

220. EMPLOYEE HEALTH.

01. Reporting of Norovirus. Addition to Section 2-201.11. The addition of Norovirus to illnesses required to be reported. ( )

a. A person diagnosed or ill with Norovirus within the past forty-eight (48) hours is required to report the illness to the person in charge. ( )

b. A food employee, who lives in the same household and has knowledge of a person who is diagnosed with Norovirus, is required to report that information to the person in charge. ( )

02. Exclusion and Restrictions. Addition to Section 2-201.12. In addition, ~~T~~the person in charge of a food establishment must: ( )

a. ~~n~~Notify the regulatory authority to obtain guidance on proper actions needed to protect the public if there is reason to suspect that any employee has a disease that is communicable through food as listed in IDAPA 16.02.10. "Idaho Reportable Diseases~~,~~" ~~*Subsection 025.02.*~~; ~~*(4-6-05)*~~(____)

b. Exclude a food employee diagnosed with an infection from Norovirus when symptomatic; (____)

c. Restrict a food employee diagnosed with an infection from Norovirus when asymptomatic; and (____)

d. Exclude a food employee diagnosed with an infection from Norovirus whether symptomatic or asymptomatic when serving a highly susceptible population. (____)

03. Removal of Exclusion and Restrictions. Addition to Section 2-201.13. In addition, the person in charge may remove an employee diagnosed with Norovirus from restriction or exclusion when one (1) of the following conditions is met: (____)

a. Written medical documentation is provided from a licensed medical practitioner; (____)

b. Forty-eight (48) hours have passed since the employee became asymptomatic; or (____)

c. Employee did not develop symptoms and more than forty-eight (48) hours have passed since the employee was diagnosed with Norovirus. (____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.27 - IDAHO RADIATION CONTROL RULES

DOCKET NO. 16-0227-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 56-1041, 56-1043, 56-1044, and 56-1046, Idaho Code, and Senate Bill 1148 (2007).

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 1, 2007, Idaho Administrative Bulletin, Vol. 07-8, pages 62 through 93.

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 to the state general fund related to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact David Eisentrager at (208) 334-2235 ext. 245.

DATED this 4th day of October, 2007.

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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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0227-0701***
Idaho Radiation Control Rules ***PENDING RULE***

THE FOLLOWING NOTICE 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 56-1041, 56-1043, 56-1044, and 56-1046, Idaho Code; Senate Bill 1148 (2007); and the Idaho Administrative Procedure Act, 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, August 15, 2007.

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 section in this chapter that contains the legal authority for rulemaking was updated by deleting obsolete citations to Idaho Code and adding the correct citations. One outdated citation to Idaho Code that was deleted is now administered by the Department of Environmental Quality. Another citation that was deleted referred to obsolete sections of statute related to radiation control that were deleted by Senate Bill 1148 (2007). The legal authority section was also missing the correct citations that state that rulemaking authority for this chapter rests with the Board of Health and Welfare and the Director of the Department; these citations were added.

In addition, the rest of the sections at the beginning of the chapter required by the Administrative Procedure Act (APA) were either updated to meet the Department's plain language standard or added because they are missing. Addition of the missing "required sections" brings the rule chapter into compliance with the APA.

Finally, to facilitate the updating of definitions in the future, the chapter's lengthy "Definitions" section was split into four smaller sections.

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 is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because these rule changes are being made to bring the chapter into compliance with the Idaho Administrative Procedure Act (APA) and to reflect the changes

made to Title 39, Chapter 30, Idaho Code ("Radiation and Nuclear Material") under Senate Bill 1148 passed by the 2007 Legislature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact David Eisentrager at (208) 334-2235 ext. 245.

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 22, 2007.

DATED this 14th day of June, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
~~*The Idaho Legislature in Title 39, Chapters 1 and 30, Idaho Code, has granted to the Board of Health and Welfare the authority to adopt rules governing the control of radiation to protect the health of the citizens of the state. The Idaho Legislature in Title 39, Chapters 1 and 30, Idaho Code, has granted the Director of the Department of Health and Welfare the authority to enforce rules adopted by the Idaho State Board of Health and Welfare.*~~ The Idaho Legislature, under the following Sections of statute has granted authority to the Board of Health and Welfare and the Director of the Department to adopt rules related to x-ray producing machines in order to protect the health of the people of Idaho. Sections 56-1041 and 56-1043, Idaho Code, grant authority to the Board of Health and Welfare to adopt radiation control rules. Section 56-1041, Idaho Code, establishes the Department as the designated agency to regulate, license, and control radiation associated with x-ray machines. Section 56-1044, Idaho Code, requires that radiation machines for mammography be registered with the Department, as provided in rule. Section 56-1046, Idaho Code, grants authority to the Department to establish record-keeping and reporting requirements for those who possess or use an x-ray machine. ~~*(7-1-98)*~~( )

001. TITLE~~*AND SCOPE*~~.
~~*These rules shall be cited, in full, as Idaho Department of Health and Welfare Rules,*~~ The title of these rules is IDAPA 16.02.27, "Idaho Radiation Control Rules." Except as otherwise specifically provided, these rules apply to all persons who possess, use, transfer, own or acquire any radiation machine. ~~*(7-1-98)*~~( )

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

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

004. INCORPORATION BY REFERENCE.
The following document is incorporated by reference in these rules: National Council of

Radiation Protection (NCRP) Report No. 147, entitled: "Structural Shielding Design and Evaluation for Medical Use of X-rays and Gamma Rays of Energies up to Ten (10) MeV," issued November 19, 2004, by the National Council on Radiation Protection and Measurement. This document may be obtained from: NCRP Publications, 7910 Woodmont, Bethesda, MD 20814. (____)

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE -- 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. (____)

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

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

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

05. Internet Website Address. The website address is: 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. (____)

007. -- 009. (RESERVED).

0~~02~~10. DEFINITIONS -- A THROUGH E.
~~*As used in*~~ For the purposes of these rules, the following terms ~~*have the definitions set forth*~~ are used as defined below: ~~*(7-1-98)*~~(____)

01. Accessible Surface. The external surface of the enclosure or housing provided by the manufacturer. (7-1-98)

02. Act. The "Radiation and Nuclear Material Act," Sections 39-3001 through 39-3024, Idaho Code. (7-1-98)

03. Added Filtration. Any filtration added to the inherent filtration. (7-1-98)

04. Aluminum Equivalent. The thickness of aluminum (Type 1100) affording the same attenuation, under specified conditions, as the material in question. (7-1-98)

05. Analytical X-Ray Equipment. Equipment used for x-ray diffraction or fluorescence analysis. (7-1-98)

06. Analytical X-Ray System. A group of components utilizing x-rays or gamma rays to determine the elemental composition or to examine the microstructure of material. (7-1-98)

07. Assembler. Any person engaged in the business of assembling, replacing, or installing one (1) or more components into an x-ray system or subsystem. The term includes the owner of an x-ray system or his employee or agent who assembles components into an x-ray system that is subsequently used to provide professional or commercial services. (7-1-98)

08. Attenuation Block. A block or stack, having dimensions twenty (20) centimeters by twenty (20) centimeters by three and eight-tenths (3.8) centimeters, of type 1100 aluminum alloy or other materials having equivalent attenuation. (7-1-98)

09. Automatic Exposure Control. A device which automatically controls one (1) or more technique factors in order to obtain at a preselected location(s) a required quantity of radiation (see also "Phototimer"). (7-1-98)

10. Beam Limiting Device. A device which provides a means to restrict the dimensions of the x-ray field, such as but not limited to collimator, diaphragm, or cone. (7-1-98)

11. Cabinet Radiography. Industrial radiography using radiation machines, which is conducted in an enclosed, interlocked cabinet, such that the radiation machine will not operate unless all openings are securely closed, and the cabinet is so shielded that every location on the exterior meets conditions for an unrestricted area as specified in Subsection 110.04. (7-1-98)

12. Cabinet X-Ray System. An x-ray system with the x-ray tube installed in an enclosure (hereinafter termed cabinet) which, independently of existing architectural structures except the floor on which it may be placed, is intended to contain at least that portion of a material being irradiated, provide radiation attenuation and exclude personnel from its interior during generation of x-radiation. Included are all x-ray systems designed primarily for the inspection of carry-on baggage at airline, railroad and bus terminals and in similar facilities. An x-ray tube used within a shielded part of a building, or x-ray equipment which may temporarily or occasionally incorporate portable shielding is not considered a cabinet x-ray system. (7-1-98)

13. Calendar Quarter. Not less than twelve (12) consecutive weeks nor more than fourteen (14) consecutive weeks. The first calendar quarter of each year will begin in January and subsequent calendar quarters will be arranged so that no day is included in more than one (1) calendar quarter and no day in any one (1) year is omitted from inclusion within a calendar quarter. (7-1-98)

14. Calibration. The determination of: (7-1-98)

a. The response or reading of an instrument relative to a series of known radiation

values over the range of the instrument; or (7-1-98)

b. The strength of a source of radiation relative to a standard. (7-1-98)

15. Certified Cabinet X-Ray System. A cabinet x-ray system which has been certified in accordance with 21 CFR 1010.2 as having been manufactured, assembled and maintained pursuant to the provisions of 21 CFR 1020.40. (7-1-98)

16. Certified Components. Components of x-ray systems which are subject to regulations promulgated under P.L. 90-602 which is available at all county law libraries. (7-1-98)

17. Certified System. Any x-ray system which has one (1) or more certified components. (7-1-98)

18. CFR. Code of Federal Regulations. (7-1-98)

19. Collimator. A device or mechanism by which the x-ray beam is restricted in size. (7-1-98)

20. Control Panel. That part of the x-ray control upon which are mounted the switches, knobs, pushbuttons, and other hardware necessary for manually setting the technique factors. (7-1-98)

21. Dead-Man Switch. A switch so constructed that a circuit-closing contact can be maintained only by continuous pressure on the switch by the operator. (7-1-98)

22. Diagnostic Source Assembly. The tube housing assembly with a beam-limiting device attached. (7-1-98)

23. Diagnostic X-Ray System. An x-ray system designed for irradiation of any part of the human body for the purpose of diagnosis or visualization. (7-1-98)

24. Dose. Absorbed dose or dose equivalent as appropriate. (7-1-98)

a. Absorbed dose is the energy imparted to matter by ionizing radiation per unit mass of irradiated material at the place of interest. The special unit of absorbed dose is the rad (see "Rad"). (7-1-98)

b. Dose equivalent is a quantity that expresses on a common scale for all radiation a measure of the postulated effect on a given organ. It is defined as the absorbed dose in rads times certain modifying factors. The unit of dose equivalent is the rem (see "Rem"). (7-1-98)

25. Entrance Exposure Rate. The exposure per unit time at the point where the center of the useful beam enters the patient. (7-1-98)

26. Exposure. The quotient of dQ by dm where "dQ" is the absolute value of the total charge of the ions of one (1) sign produced in air when all the electrons (negatrons and positrons) liberated by photons in a volume element of air having mass "dm" are completely stopped in air

(the special unit of exposure is the roentgen (R)). (7-1-98)

27. Exposure Rate. The exposure per unit of time, such as roentgen per minute and milliroentgen per hour. (7-1-98)

011. DEFINITIONS -- F THROUGH O.
For the purposes of these rules, the following terms are used as defined below: (____)

~~28~~01. Facility. The location at which one (1) or more radiation machines are installed ~~and/~~or located within one (1) building, vehicle, or under one (1) roof and are under the same administrative control. ~~(7-1-98)~~(____)

~~29~~02. Fail-Safe Characteristics. A design feature which causes beam port shutters to close, or otherwise prevents emergence of the primary beam, upon the failure of a safety or warning device. (7-1-98)

~~30~~03. Filter. Material placed in the useful beam to absorb preferentially the less penetrating radiations. (7-1-98)

~~31~~04. Fluoroscopic Imaging Assembly. A component which comprises a reception system in which x-ray photons produce a fluoroscopic image, including equipment housings, electrical interlocks if any, the primary protective barrier, and structural material providing linkage between the image receptor and the diagnostic source assembly. (7-1-98)

~~32~~05. General Purpose Radiographic X-Ray System. Any radiographic x-ray system which, by design, is not limited to radiographic examination of specific anatomical regions. (7-1-98)

~~33~~06. Gonadal Shield. A protective barrier for the testes or ovaries. (7-1-98)

~~34~~07. Half-Value Layer (HVL). The thickness of a specified substance which, when introduced into the path of a given beam of radiation, reduces the exposure rate by one-half (1/2). (7-1-98)

~~35~~08. Healing Arts. Medicine, dentistry, chiropractic, podiatry, osteopathy, and veterinary medicine. (7-1-98)

~~36~~09. Healing Arts Screening. The testing of human beings using x-ray machines for the detection or evaluation of health indications when such tests are not specifically and individually ordered by a licensed practitioner of the healing arts legally authorized to prescribe such x-ray tests for the purpose of diagnosis or treatment. (7-1-98)

~~37~~10. High Radiation Area. Any area, accessible to individuals, in which there exists radiation at such levels that a major portion of the body could receive in any one (1) hour a dose in excess of one hundred (100) millirems. (7-1-98)

~~38~~11. Human Use. The internal or external administration of radiation to human beings. (7-1-98)

~~**39**~~**12. Image Intensifier**. A device, including housing, which instantaneously converts an x-ray pattern into a corresponding light image of higher energy density. (7-1-98)

~~**40**~~**13. Image Receptor**. Any device, such as a fluorescent screen or radiographic film, which transforms incident x-ray photons either into a visible image or into another form which can be made into a visible image by further transformations. (7-1-98)

~~**41**~~**14. Individual**. Any human being. (7-1-98)

~~**42**~~**15. Industrial Radiography**. The examination of the macroscopic structure of materials by nondestructive methods utilizing sources of radiation. (7-1-98)

~~**43**~~**16. Inherent Filtration**. The filtration permanently in the useful beam, including the window of the x- ray tube and any permanent tube or source enclosure. (7-1-98)

~~**44**~~**17. Inspection**. An official examination or observation including but not limited to, tests, surveys, and monitoring to determine compliance with rules, regulations, orders, requirements and conditions of the Radiation Control Agency. (7-1-98)

~~**45**~~**18. Interlock**. A device arranged or connected such that the occurrence of an event or condition is required before a second event or condition can occur or continue to occur. (7-1-98)

~~**46**~~**19. Kilovolts Peak (kVp)**. See "Peak Tube Potential." (7-1-98)

~~**47**~~**20. Lead Equivalent**. The thickness of lead affording the same attenuation, under specified conditions, as the material in question. (7-1-98)

~~**48**~~**21. Leakage Radiation**. Radiation emanating from the diagnostic or therapeutic source assembly except for: (7-1-98)

a. The useful beam; and (7-1-98)

b. Radiation produced when the exposure switch or timer is not activated. (7-1-98)

~~**49**~~**22. Leakage Technique Factors**. The technique factors associated with the diagnostic or therapeutic source assembly which are used in measuring leakage radiation. They are defined as follows: (7-1-98)

a. For diagnostic source assemblies intended for capacitor energy storage equipment, the maximum- rated peak tube potential and the maximum-rated number of exposures in an hour for operation at the maximum-rated peak tube potential with the quantity of charge per exposure being ten (10) millicoulombs, i.e., ten (10) milliampere seconds, or the minimum obtainable from the unit, whichever is larger. (7-1-98)

b. For diagnostic source assemblies intended for field emission equipment rated for pulsed operation, the maximum-rated peak tube potential and the maximum-rated number of x-ray pulses in an hour for operation at the maximum- rated peak tube potential. (7-1-98)

~~**50**~~**23. Light Field**. That area of the intersection of the light beam from the beam-limiting device and one (1) of the set of planes parallel to and including the plane of the image receptor, whose perimeter is the locus of points at which the illumination is one-fourth (1/4) of the maximum in the intersection. (7-1-98)

~~**51**~~**24. Local Components**. Part of an analytical x-ray system including areas that are struck by x-rays such as radiation source housings, port and shutter assemblies, collimators, sample holders, cameras, goniometers, detectors, and shielding, but not including power supplies, transformers, amplifiers, readout devices, and control panels. (7-1-98)

~~**5**~~**25. Normal Operating Procedures**. Step-by-step instruction necessary to accomplish the analysis. These procedures must include sample insertion and manipulation, equipment alignment, routine maintenance by the registrant and data recording procedures, which are related to radiation safety. (7-1-98)

~~**53**~~**26. Occupational Dose**. Exposure of an individual to radiation in a restricted area or exposure in the course of employment in which the individual's duties involve exposure to radiation, provided, that occupational dose will not be deemed to include any exposure of an individual to radiation for the purpose of diagnosis or therapy of such individual. (7-1-98)

~~**54**~~**27. Open Beam Configuration**. An analytical x-ray system in which an individual could accidently place some part of his body in the primary beam path during normal operation. (7-1-98)

012. DEFINITIONS -- P THROUGH R.
For the purposes of these rules, the following terms are used as defined below: ( )

~~**55**~~**01. Particle Accelerator**. The term "particle accelerator" is very broad and covers many types of devices. It is generally defined as a device used to impart kinetic energy to electrically charged particles such as electrons, protons, deuterons, and helium ions, and is referred to herein to designate devices that accelerate particles to energies greater than approximately one (1) MeV, or to neutron generators which operate with a potential of about one hundred fifty (150) kv. Such accelerators as cyclotrons, betatrons, linear accelerators, Van de Graaff accelerators, Cockcroft-Walton type neutron generators, and resonant transformers are included. (7-1-98)

~~**56**~~**02. Peak Tube Potential**. The maximum value of the potential difference across the x-ray tube during an exposure. (7-1-98)

~~**57**~~**03. Permanent Radiographic Installation**. An installation or structure designed or intended for radiography and in which radiography is regularly performed. (7-1-98)

~~**58**~~**04. Person**. Any individual, corporation, partnership, firm, association, trust, estate, public or private institution, group, agency, political subdivision of this state, any other state, or political subdivision or agency thereof, any legal successor, representative, agent or agency of the foregoing. (7-1-98)

~~59~~**05. Personal Supervision**. Supervision in which the authorized operator of an x-ray unit or radioisotopic device is physically present at the site where sources of radiation and associated equipment are being used, watching the performance of the assistant or trainee and in such proximity that immediate assistance can be given if required. (7-1-98)

~~60~~**06. Personnel Monitoring**. The determination of exposure to a person. (7-1-98)

~~61~~**07. Personnel Monitoring Equipment**. Devices designed to be worn or carried by an individual for the purpose of estimating the dose received, such as film or thermoluminescent dosimetry badges, pocket chambers, pocket dosimeters, or film and thermoluminecsent dosimetry rings. (7-1-98)

~~62~~**08. Phototimer**. A method for controlling radiation exposures to image receptors by the amount of radiation which reaches a radiation monitoring device. The radiation monitoring device is part of an electronic circuit which controls the duration of time the tube is activated. (7-1-98)

~~63~~**09. Physician**. An individual licensed by the Idaho State Board of Medicine to practice medicine. (7-1-98)

~~64~~**10. Position Indicating Device (PID)**. A device on dental x-ray equipment used to indicate the beam position and to establish a definite source-surface (skin) distance. It may or may not incorporate or serve as a beam- limiting device. (7-1-98)

~~65~~**11. Primary Beam**. Radiation which passes through an aperture of the source housing by a direct path from the x-ray tube or a radioactive source located in the radiation source housing. (7-1-98)

~~66~~**12. Protective Apron**. Apron made of radiation absorbing materials, used to reduce radiation exposure. (7-1-98)

~~67~~**13. Protective Barrier**. A barrier of radiation attenuating materials used to reduce radiation exposure. (7-1-98)

a. Primary Protective Barrier. A barrier sufficient to attenuate the useful beam to the required degree to assure compliance with Subsections 110.01, 110.03, and 110.04. (7-1-98)

b. Secondary Protective Barrier. A barrier sufficient to attenuate stray radiation to the required degree to assure compliance with Subsections 110.01, 110.03, and 110.04. (7-1-98)

~~68~~**14. Protective Glove**. Glove made of radiation absorbing materials used to reduce radiation exposure. (7-1-98)

~~69~~**15. Qualified Expert**. An individual who has demonstrated to the satisfaction of the Radiation Control Agency that such individual possesses the knowledge and training to measure ionizing radiation, to evaluate safety techniques, and to advise regarding radiation protection needs. (7-1-98)

~~70~~16. Rad. The special unit of absorbed dose. One (1) rad equals one one-hundredth (.01) of a joule per kilogram of material. For example, if tissue is the material of interest, then one (1) rad equals one hundred (100) ergs per gram of tissue. (7-1-98)

~~7~~17. Radiation. Ionizing radiation, that is, gamma rays and x-rays, alpha and beta particles, high speed electrons, neutrons, protons, and other atomic particles. (7-1-98)

~~72~~18. Radiation Area. Any area, accessible to individuals, in which there exists radiation at such levels that a major portion of the body could receive in any one (1) hour a dose in excess of five (5) millirem, or in any five (5) consecutive days a dose in excess of one hundred (100) millirem. (7-1-98)

~~73~~19. Radiation Control Agency. The Idaho Department of Health and Welfare. (7-1-98)

~~74~~20. Radiation Machine. Any device capable of producing radiation except devices which produce radiation only from radioactive material. (7-1-98)

~~75~~21. Radiation Safety Officer. An individual who has the knowledge and responsibility to apply appropriate radiation protection principles and rules. (7-1-98)

~~76~~22. Radiograph. An image receptor on which the image is created directly or indirectly by an x-ray pattern and results in a permanent record. (7-1-98)

~~77~~23. Radiographer. Any individual who performs or who, in attendance at the site where sources of radiation are being used, personally supervises industrial radiographic operations and who is responsible to the licensee or registrant for assuring compliance with the requirements of these rules and all conditions of licensure. (7-1-98)

~~78~~*24*. Radiographer's Assistant. Any individual who, under the personal supervision of a radiographer, uses sources of radiation, related handling tools, or survey instruments in industrial radiography. (7-1-98)

~~79~~25. Radiographic Imaging System. Any system whereby a permanent or semi-permanent image is recorded on an image receptor by the action of ionizing radiation. (7-1-98)

~~80~~26. Radiological Physicist. An individual who: (7-1-98)

a. Is certified by the American Board of Radiology in therapeutic radiological physics, radiological physics, or x- and gamma-ray physics; or (7-1-98)

b. Has a bachelor's degree in one of the physical sciences or engineering and three (3) years full-time experience working in therapeutic radiological physics under the direction of a physicist certified by the American Board of Radiology. The work duties must include duties involving the calibration and spot-checks of a medical accelerator or a sealed source teletherapy unit; or (7-1-98)

c. Has a Master's or a Doctor's degree in physics, biophysics, radiological physics,

health physics, or engineering; has had one (1) year's full-time training in therapeutic radiological physics; and has had one (1) year's full-time work experience in a radiotherapy facility where the individual's duties involve calibration and spot-checks of a medical accelerator or a sealed source teletherapy unit. (7-1-98)

~~81~~27. Rating. The operating limits as specified by the component manufacturer.(7-1-98)

~~82~~28. Registrant. Any person who owns or possesses any device capable of emitting radiation which is registered with the Radiation Control Agency. (7-1-98)

~~83~~29. Registration. The filing with the Radiation Control Agency of all devices capable of emitting radiation in accordance with these rules. (7-1-98)

~~84~~30. Rem. A measure of dose equivalent. One (1) millirem (mrem) equals one one-thousandth (.001) rem. For the purpose of these rules, any of the following is considered to be equivalent to a dose of one (1) rem: (7-1-98)

a. An exposure of one (1) R of x-, or gamma radiation; or (7-1-98)

b. An absorbed dose of one (1) rad due to x-, gamma, or beta radiation; or (7-1-98)

c. An absorbed dose of one-tenth (0.1) rad due to neutrons or high energy protons. (7-1-98)

d. If it is more convenient to measure the neutron flux, or equivalent, than to determine the neutron dose in rads, one (1) rem of neutron radiation can, for purposes of these rules, be assumed to be equivalent to fourteen million (14,000,000) neutrons per square centimeter incident upon the body; or, if there exists sufficient information to estimate with reasonable accuracy the approximate distribution in energy of the neutrons, the incident number of neutrons per square centimeter equivalent to one (1) rem can be estimated from the following table.

NEUTRON FLUX DOSE EQUIVALENTS TABLE		
Neutron Energy (MeV)	**Number of Neutrons per Square Centimeter Equivalent to a Dose of 1 Rem (Neutron/cm^2)**	**Average Flux to Deliver 100 Millirem in 40 Hours (Neutrons/ cm^2 per Second)**
Thermal	970×10^6	670
0.001	720×10^6	500
0.005	820×10^6	570
0.02	400×10^6	280
0.1	120×10^6	80
0.5	43×10^6	30
1.0	26×10^6	18
2.5	29×10^6	20

NEUTRON FLUX DOSE EQUIVALENTS TABLE		
Neutron Energy (MeV)	Number of Neutrons per Square Centimeter Equivalent to a Dose of 1 Rem (Neutron/cm^2)	Average Flux to Deliver 100 Millirem in 40 Hours (Neutrons/ cm^2 per Second)
5.0	26 x 10^6	18
7.5	24 x 10^6	17
10.0	24 x 10^6	17
10 to 30	14 x 10^6	10

(7-1-98)

e. An absorbed dose of five one-hundredths (0.05) rad due to particles heavier than protons and with sufficient energy to reach the lens of the eye. (7-1-98)

***85*31. Restricted Area**. Any area access to which is controlled by the licensee or registrant for purposes of protection of individuals from exposure to radiation ~~*and/or radioactive material*~~. Restricted area does not include any areas used for residential quarters, although a separate room or rooms in a residential building can be set apart as a restricted area.
~~*(7-1-98)*~~(____)

***86*32. Roentgen**. A measure of the exposure of x- or gamma radiation in terms in the electric charge produced in air. One (1) Roentgen (R) is defined as the amount of x- or gamma radiation required to produce by ionization 2.58 x 10^4 coulomb of ions per kilogram of dry air.
(7-1-98)

013. DEFINITIONS -- S THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (____)

***87*01. Scattered Radiation**. Radiation that, during passage through matter, has been deviated or deflected in direction. (7-1-98)

***88*02. Shielded Room Radiography**. Industrial radiography conducted in an enclosed room so shielded that every location on the exterior meets the conditions as specified in Subsection 110.04. (7-1-98)

***89*03. Shutter**. A device, attached to the tube housing assembly which can totally intercept the useful beam and which has a lead equivalency not less than that of the tube housing assembly. (7-1-98)

***9*04. Source-Image Receptor Distance (SID)**. The distance from the source to the center of the input surface of the image receptor. (7-1-98)

***91*05. Source of Radiation**. Any radioactive material, or any device or equipment emitting or capable of producing radiation. (7-1-98)

~~92~~06. Spot Film. A radiograph which is made during a fluoroscopic examination to permanently record conditions which exist during that fluoroscopic procedure. (7-1-98)

~~93~~07. Spot Film Device. A device intended to transport ~~and/~~or position, or both, a radiographic image receptor between the x-ray source and fluoroscopic image receptor, including clip-on cassette holders. ~~(7-1-98)~~( )

~~94~~08. SSD (Source Skin Distance). The distance between the source of radiation and the skin of the patient. (7-1-98)

~~95~~09. Stray Radiation. The sum of leakage and scattered radiation. (7-1-98)

~~96~~10. Survey. An evaluation of the production, use, or release~~, disposal, and/or presence~~ of sources of radiation under a specific set of conditions to determine actual or potential radiation hazards. When appropriate, such evaluation includes, but is not limited to tests, physical examination, and measurements of levels of radiation or concentration of radioactive material present. ~~(7-1-98)~~( )

~~97~~11. Technique Factors. The conditions of operation are specified as follows: (7-1-98)

a. For capacitor energy storage equipment, peak tube potential in kV and quantity of charge in mAs; and (7-1-98)

b. For field emission equipment rated for pulsed operation, peak tube potential in kV and number of x-ray pulses; and (7-1-98)

c. For all other equipment, peak tube potential in kV and either tube current in mA and exposure time in seconds, or the product of tube current and exposure time in mAs. (7-1-98)

~~98~~12. Temporary Job Site. Any location where industrial radiography is performed other than the location(s) listed in a certificate of registration. (7-1-98)

~~99~~13. Termination of Irradiation. The stopping of irradiation in a fashion which will not permit continuance of irradiation without the resetting of operating conditions at the control panel. (7-1-98)

1~~00~~4. Test. The process of certifying compliance with an applicable rules. (7-1-98)

~~10~~15. These Rules. Idaho Department of Health and Welfare Rules, IDAPA 16, Title 02, Chapter 27, Sections 000 through 999, "Idaho Radiation Control Rules." (7-1-98)

1~~02~~6. Traceable to a National Standard. When a quantity or a measurement has been compared to a national standard directly or indirectly through one (1) or more intermediate steps and when all comparisons have been documented. (7-1-98)

1~~03~~7. Tube. An x-ray tube, unless otherwise specified. (7-1-98)

1~~04~~8. Tube Housing Assembly. The tube housing with tube installed, including high-

voltage and~~/or~~ filament transformers and other appropriate elements when contained within the tube housing. ~~(7-1-98)~~(____)

1~~05~~9. Tube Rating Chart. The set of curves which specify the rated limits of operation of the tube in terms of the technique factors. (7-1-98)

~~106~~20. Unrestricted Area. Any area access to which is not controlled by the licensee or registrant for purposes of protection of individuals from exposure to radiation and radioactive materials, and any area used for residential quarters. (7-1-98)

~~107~~21. Useful Beam. The radiation emanating from the tube housing port or the radiation head and passing through the aperture of the beam-limiting device when the exposure controls are in a mode to cause the system to produce radiation. (7-1-98)

~~108~~22. Variable-Aperture Beam-Limiting Device. A beam-limiting device which has capacity for stepless adjustment of the x-ray field size at a given source to image distance (SID). (7-1-98)

~~109~~23. Visible Area. That portion of the input surface of the image receptor over which incident x-ray photons are producing a visible image. (7-1-98)

~~110~~24. Worker. An individual engaged in work under a registration issued by the Radiation Control Agency and controlled by a registrant, not including the registrant. (7-1-98)

~~111~~25. X-Ray Control. A device which controls input power to the x-ray high-voltage generator and~~/or~~ the x-ray tube, including equipment such as timers, phototimers, automatic brightness stabilizers and similar devices which control the technique factors of an x-ray exposure. ~~(7-1-98)~~(____)

~~11~~26. X-Ray Equipment. An x-ray system, subsystem or component thereof. (7-1-98)

a. Mobile. X-ray equipment mounted on a permanent base with wheels ~~and/~~or casters for moving while completely assembled. ~~(7-1-98)~~(____)

b. Portable. X-ray equipment designed to be hand-carried. (7-1-98)

c. Stationary. X-ray equipment installed in a fixed location. (7-1-98)

~~113~~27. X-Ray Field. That area of the intersection of the useful beam and any one (1) of the set of planes parallel to and including the plane of the image receptor, whose perimeter is the locus of points at which the exposure rate is one-fourth (1/4) of the maximum in the intersection. (7-1-98)

~~114~~28. X-Ray High-Voltage Generator. A device which transforms electrical energy from the potential supplied by the x-ray control to the tube operating potential, including but not limited to a means for transforming alternating current to direct current, filament transformers for the x-ray tube(s), high-voltage switches, electrical protective devices and other appropriate elements. (7-1-98)

***115*29. X-Ray Source**. The focal spot of the x-ray tube. (7-1-98)

***116*30. X-Ray System**. An assemblage of components for the controlled production of x-rays, including an x-ray high-voltage generator, an x-ray control, a tube housing assembly, a beam-limiting device and the necessary supporting structures; additional components which function with the system are considered integral parts of the system. (7-1-98)

***117*31. X-Ray Tube**. Any electron tube which is designed for the conversion of electrical energy into x-ray energy. (7-1-98)

003. – 005 **014.(RESERVED).**

0*06*15. EXEMPTIONS.
The Radiation Control Agency can, upon application therefor or upon its own initiative, grant such exemptions or exceptions from the requirements of these rules as it determines are authorized by law and will not result in undue hazard to public health and safety *and/*or property. *(7-1-98)*(____)

0*07*16. RECORDS.
Each registrant must keep records showing the receipt, transfer, and disposal of all radiation machines. Additional record requirements are specified elsewhere in these rules. (7-1-98)

0*08*17. INSPECTIONS.

01. Preregistration Inspections. The Agency has the right to conduct prelicensing inspections to verify information contained in applications and secure additional information deemed necessary to make a reasonable determination as to whether to issue a registration and whether any special conditions must be attached thereto by visiting the facility or location where radiation machines would be possessed or used. (7-1-98)

02. Inspections of Facilities. Each registrant must afford the Agency at all reasonable times opportunity to inspect radiation machines and the premises and facilities wherein such radiation machines are used or stored. (7-1-98)

03. Inspections of Records. Each registrant will make available to the Agency for inspection, upon reasonable notice, records maintained pursuant to these rules. (7-1-98)

0*09*18. TESTS.
Each registrant must perform or permit the Radiation Control Agency to perform such reasonable tests as the Radiation Control Agency deems appropriate or necessary including, but not limited to, tests of radiation machines, facilities wherein radiation machines are used or stored, radiation detection and monitoring instruments, and other equipment and devices used in connection with utilization or storage of registered radiation machines. (7-1-98)

01*0*9. ADDITIONAL REQUIREMENTS.
The Radiation Control Agency can, by registration condition, impose upon any registrant such requirements in addition to those established in these rules as it deems appropriate or necessary to

minimize danger to public health and safety ~~and/~~or property. ~~(7-1-98)~~(____)

0~~11~~20. VIOLATIONS.
An injunction or other court order can be obtained prohibiting any violations of any provision of the Act or any rule, regulation, or order issued thereunder. Any person who willfully violates any provision of the Act or any rule, regulation, or order issued thereunder could be guilty of a crime and, upon conviction, could be punished by fine or imprisonment or both, as provided by law. (7-1-98)

0~~1~~21. IMPOUNDING.
Radiation machines are subject to impoundment pursuant to Section 39-3014, Idaho Code. (7-1-98)

0~~13~~22. PROHIBITED RADIATION USES.

01. Radiation Sources Used for Shoe Sizing. It is unlawful to operate any device or machine using fluoroscopic x-ray or radiation principles for fitting or selling footwear. (7-1-98)

02. Unauthorized Use on Humans. It is unlawful to intentionally apply ionizing radiation to human beings except by or under direct supervision of persons, other than veterinarians, licensed to practice healing arts and authorized to use such radiation or as otherwise provided in these rules related to exposures. (7-1-98)

03. General Health and Safety. The Radiation Control Agency shall have the authority to prohibit the use of radiation machines when found to be detrimental to health and safety. (7-1-98)

0~~14~~23. COMMUNICATIONS.
All communications and reports concerning these rules, and applications filed thereunder, may be addressed to the Radiation Control Section, Idaho Department of Health and Welfare, Bureau of Laboratories, 2220 Old Penitentiary Road, Boise, Idaho 83712-8299. (7-1-98)

0~~15~~24. -- 049. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

051. SCOPE.
Radiation machines, unless exempt under Section 0~~06~~15 ~~and~~ or Section 053 of these rules, must be registered with the Radiation Control Agency in accordance with the requirements of Section 090. ~~(7-1-98)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

091. ~~*ADMINISTRATIVE APPEAL OF FINAL REGISTRATION DECISIONS*~~ (RESERVED).
~~*Within thirty (30) days after a final registration decision has been issued pursuant to Sections 050 through 090 the applicant may petition the Radiation Control Agency to review the decision in accordance with this Section. The thirty (30) day period within which an applicant may request review under this Section begins with the service of notice of the Radiation Control Agency's decision unless a later date is specified in that notice. Any petition for administrative review shall be in writing and state the reasons supporting review. Within a reasonable time following filing of a petition for review, the Radiation Control Agency shall hold a hearing in accordance with Title 67, Chapter 52, Idaho Code, and issue a final decision.*~~ ~~*(7-1-98)*~~

092. MODIFIED REVOCATION OF REGISTRATION.

01. Modification, Revocation, and Termination of Registrants. Pursuant to amendments to the Act, departmental rules or regulations, or orders issued by the Radiation Control Agency, the terms and conditions of all registrations are subject to amendment, revision, or modification, and are subject to suspension or revocation. (7-1-98)

a. Any registration can be revoked, suspended, modified, or denied, in whole or in part. (7-1-98)

i. For any materially false statement: (7-1-98)

(1) In the application; or (7-1-98)

(2) In any statement of fact required under provisions of the Act or under these rules; or (7-1-98)

ii. Because of the conditions revealed: (7-1-98)

(1) By the application; or (7-1-98)

(2) By statement of fact; or (7-1-98)

(3) By any report; or (7-1-98)

(4) By any record; or (7-1-98)

(5) By any inspection; or (7-1-98)

(6) By any other means which would warrant the Radiation Control Agency to refuse to grant a registration on an original application; or (7-1-98)

iii. For violations of or failure to observe any of the terms and conditions: (7-1-98)

(1) Of the Act; or (7-1-98)

(2) Of the license; or (7-1-98)

(3) Of any rule; or (7-1-98)

(4) Of any regulation; or (7-1-98)

(5) Of an order of the Radiation Control Agency. (7-1-98)

b. Except in cases of willful violation or in which the public health, interest or safety requires otherwise, no registration can be modified, suspended, or revoked unless, prior to the institution of proceedings therefor, the facts or conduct which warrant such actions have been called to the attention of the registrant in writing and the registrant must have been accorded an opportunity to demonstrate or achieve compliance with all lawful requirements. (7-1-98)

02. Emergency Action. If the Director finds the public health, safety or welfare requires emergency action, the Director ~~*shall*~~ will incorporate findings in support of such action in a written notice of emergency revocation issued to the registrant. Emergency revocation ~~*shall be*~~ is effective upon receipt by the registrant. Thereafter, if requested by the registrant in writing, the Director ~~*shall*~~ will provide the registrant a revocation hearing and prior notice thereof. Such hearings ~~*shall be*~~ are conducted in accordance with ~~*Title 67, Chapter 52, Idaho Code*~~ IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings."
~~*(7-1-98)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

110. OCCUPATIONAL EXPOSURES.

01. Exposure of Individuals to Radiation in Restricted Areas. Except as provided in Subsection 110.01.b., no registrant may possess, use, receive, or transfer radiation machines in such a manner as to cause any individual in a restricted area to receive in any period of one (1) calendar quarter from all radiation machines in the registrant's possession a dose in excess of the limits specified in Subsection 110.01.a.: (7-1-98)

a. Occupational Exposure Limits.

OCCUPATIONAL EXPOSURE LIMITS	
	Rem Per Calendar Quarter
Whole body, head and trunk, active blood-forming organs, lens of eyes, or gonads	1 1/4
Hands and forearms, feet and ankles	18 3/4

OCCUPATIONAL EXPOSURE LIMITS	
	Rem Per Calendar Quarter
Skin of whole body	7 1/2

(7-1-98)

b. A registrant may permit an individual in a restricted area to receive a dose to the whole body greater than that permitted in the table in Subsection 110.01.a., provided: (7-1-98)

i. During any calendar quarter the dose to the whole body from radiation machines in the registrant's possession does not exceed three (3) rem; and (7-1-98)

ii. The dose to the whole body, when added to the accumulated occupational dose to the whole body, does not exceed five (5) (N-18) rem where "N" equals the individual's age in years at his last birthday; and (7-1-98)

iii. The registrant has determined the individual's accumulated occupational dose to the whole body on a clear and legible record containing all the information required pursuant to Subsection 140.01.a. and has otherwise complied with the requirements of Subsection 110.02 as used in Subsection 110.01.b. "Dose to the whole body" includes any dose to the whole body, gonads, active blood-forming organs, head and trunk, or lens of the eye. (7-1-98)

c. For determining the doses specified in Section 110 a dose from x-rays or gamma rays up to ten (10) MeV can be assumed to be equivalent to the exposure measured by a properly calibrated appropriate instrument in air at or near the body surface in the region of the highest dose rate. (7-1-98)

d. No registrant can change the method observed by him of determining calendar quarter for purposes of these rules except at the beginning of a calendar year from Subsection ~~*002.14*~~ 010.13. ~~*(7-1-98)*~~( )

02. Determination of Accumulated Dose. (7-1-98)

a. Each registrant shall require any individual, prior to first entry of the individual into the registrant's restricted area during each employment or work assignment under such circumstances that the individual will receive or is likely to receive in any period of one (1) calendar quarter an occupational dose in excess of twenty-five percent (25%) of the applicable standards specified in Subsections 110.01 and 110.04.a., to disclose in a written, signed statement: (7-1-98)

i. That the individual had no prior occupational dose during the current calendar quarter; or (7-1-98)

ii. The nature and amount of any occupational dose which the individual may have received during the specifically identified current calendar quarter, from radiation machines possessed or controlled by the other persons, and each registrant shall maintain records of such

statements until the Agency authorizes disposition. (7-1-98)

b. Before permitting any individual in a restricted area to receive exposure to radiation in excess of the limits specified in Subsection 110.01, each registrant must: (7-1-98)

i. Obtain a signed certificate on a clear and legible record containing all the information required, showing each period of time after the individual attained the age of eighteen (18) in which the individual received an occupational dose of radiation (copies of certificates can be obtained from the Radiation Control Agency); and (7-1-98)

ii. Calculate, on a clear and legible record containing all the information required pursuant to Subsection 140.01.a., the previously accumulated occupational dose received by the individual and the additional dose allowed for that individual under Subsection 110.01.b. (7-1-98)

iii. In the preparation of a clear and visible record containing all the information required, make a reasonable effort to obtain reports of the individual's previously accumulated occupational dose. For each period for which the registrant obtains such report, he must use the dose shown in the report. In any case where a registrant is unable to obtain reports of the individual's occupational dose for a previous complete calendar quarter, it must be assumed that the individual has received the occupational dose specified in the following applicable columns:

ASSUMED OCCUPATIONAL DOSES		
Part of Body	**Column 1**	**Column 2**
	Assumed Dose in Rem for Calendar Quarters Prior to January 1, 1961	Assumed Dose in Rem for Calendar Quarters on or After January 1, 1961
Whole Body, gonads, active blood-forming organs, head and trunk, lens of eye	3 3/4	1 1/4

(7-1-98)

iv. The registrant shall retain and preserve all records used until the agency authorizes their disposition. If calculation of the individual's accumulated occupational dose for all periods prior to January 1, 1961, yields a result higher than the applicable accumulated dose value for the individual as of that date, as specified in Subsection 110.01.b., the excess can be disregarded. (7-1-98)

03. Exposure of Minors. Registrants must not possess, use or transfer radiation machines in such a manner as to cause any individual within a restricted area, who is under eighteen (18) years of age, to receive in any period of one (1) calendar quarter from all sources of radiation in such licensee's or registrant's possession a dose in excess of ten percent (10%) of the limits specified in the table in Subsection 110.01.a. For determining the doses specified in Subsection 110.04.a., a dose from x-rays or gamma rays up to ten (10) MeV can be assumed to be equivalent to the exposure measured by a properly calibrated appropriate instrument in air at or near the body surface in the region of the highest dose rate. (7-1-98)

04. Permissible Levels of Radiation from External Sources in Unrestricted Areas. (7-1-98)

a. Except as authorized by the Radiation Control Agency pursuant to Subsection 110.04.c., licensees or registrants must not possess, use, or transfer radiation machines in such a manner as to create in any unrestricted area from such sources of radiation in his possession: (7-1-98)

i. Radiation levels which, if an individual were continuously present in the area, could result in his receiving a dose in excess of two (2) millirem in any one (1) hour; or (7-1-98)

ii. Radiation levels which, if an individual were continuously present in the area, could result in his receiving a dose in excess of one hundred (100) millirem in any seven (7) consecutive days. (7-1-98)

b. It is the intent of Subsection 110.04 to limit radiation levels so that it is unlikely that individuals in unrestricted areas would receive a dose to the whole body in excess of five-tenths (0.5) rem in any one (1) year. If in specific instances, it is determined by the Radiation Control Agency that this intent is not being met, the Radiation Control Agency can, ~~*pursuant to*~~ under Section 01~~*0*~~9 of these rules impose such additional requirements on the licensee or registrant as necessary. ~~*(7-1-98)*~~(____)

c. Any person can apply to the Radiation Control Agency for proposed limits upon levels of radiation in unrestricted areas in excess of those specified in Subsection 110.04.a. resulting from the applicant's possession or use of radiation machines. Such applications must include information as to anticipated average radiation levels and anticipated occupancy times for each unrestricted area involved. The Radiation Control Agency will approve the proposed limits if the applicant demonstrates to the satisfaction of the Radiation Control Agency that the proposed limits are not likely to cause any individual to receive a dose to the whole body in any period of one (1) calendar year in excess of five-tenths (0.5) rem. (7-1-98)

111. -- 119. (RESERVED).

120. PRECAUTIONARY PROCEDURES.

01. Surveys. Each registrant must make or cause to be made such surveys, as defined in Subsection ~~*002.96*~~ 013.10, as necessary for him to establish compliance with these rules, and as reasonable under the circumstances to evaluate the extent of radiation hazards that may be present. ~~*(7-1-98)*~~(____)

02. Personnel Monitoring. Each registrant must supply appropriate personnel monitoring equipment to, and must require the use of such equipment by: (7-1-98)

a. Each individual who enters a restricted area under such circumstances that he receives, or is likely to receive, a dose in any one (1) calendar quarter in excess of twenty-five percent (25%) of the applicable value specified in Subsection 110.01.a.; and (7-1-98)

b. Each individual under eighteen (18) years of age who enters a restricted area under such circumstances that he receives, or is likely to receive, a dose in any one (1) calendar quarter in excess of five percent (5%) of the applicable value specified in Subsection 110.01.a.; and (7-1-98)

c. Each individual who enters a high radiation area. (7-1-98)

03. Caution Signs, Labels, and Signals. (7-1-98)

a. General: Except as otherwise authorized by the Radiation Control Agency, symbols prescribed by Subsection 120.03 must use the conventional radiation caution colors, magenta or purple on yellow background. The radiation symbol is the conventional three-bladed design as follows: (7-1-98)

i. Cross-hatched area must be magenta or purple; and (7-1-98)

ii. Background must be yellow. (7-1-98)

iii. Design must appear as indicated in Appendix A located at the end of this chapter. (7-1-98)

iv. In addition to the contents of signs and labels prescribed in this Section, a registrant can provide on or near such signs and labels any additional information which could be appropriate in aiding individuals to minimize exposure to radiation. (7-1-98)

b. Radiation Areas. Each radiation area must be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words:

"CAUTION" (or) "DANGER"
"RADIATION AREA"

(7-1-98)

c. High Radiation Areas. Each high radiation area must be conspicuously posted with a sign or signs bearing the radiation caution symbol and the words:

"CAUTION" (or) "DANGER"
"HIGH RADIATION AREA"

(7-1-98)

i. Each entrance or access point to a high radiation area must be: (7-1-98)

(1) Equipped with a control device which will cause the level of radiation to be reduced below that at which an individual might receive a dose of one hundred (100) millirem in one (1) hour upon entry into the area; or (7-1-98)

(2) Equipped with a control device which will energize a conspicuous visible or audible alarm signal in such a manner that the individual entering the high radiation area and the registrant, or a supervisor of the activity are made aware of the entry; or (7-1-98)

(3) Maintained locked except during periods when access to the area is required, with positive control over each individual entry. (7-1-98)

ii. The controls required by Subsection 120.03.c.ii. must be established in such a way that no individual will be prevented from leaving a high radiation area. (7-1-98)

iii. In the case of a high radiation area established for a period of thirty (30) days or less, direct surveillance to prevent unauthorized entry can be substituted for the controls required by Subsection 120.03.c.ii. (7-1-98)

iv. Any registrant can apply to the Radiation Control Agency for approval of methods not included in Subsections 120.03.c.ii. and 120.03.c.iv. for controlling access to high radiation area. The Radiation Control Agency will approve the proposed alternatives if the registrant demonstrates that the alternative method of control will prevent unauthorized entry into a high radiation area, and that the requirement of Subsection 120.03.c.iii. is met. (7-1-98)

121. -- 139. (RESERVED).

140. RECORDS, REPORTS, AND NOTIFICATIONS.

01. Records of Surveys and Radiation Monitoring. (7-1-98)

a. Each registrant shall maintain records showing the radiation exposures of all individuals for whom personnel monitoring is required under Subsection 120.02. Such records must be kept on clear and legible records containing all the information required below: (7-1-98)

i. Name; and (7-1-98)

ii. Social Security Number; and (7-1-98)

iii. Date of Birth; and (7-1-98)

iv. Name of Registrant; and (7-1-98)

v. Dose Records for the whole body, skin, or hands and forearms, feet and ankles; and (7-1-98)

vi. Whole Body Dose Status; and (7-1-98)

vii. Method of Monitoring; and (7-1-98)

viii. Period of Exposure; and (7-1-98)

ix. X-Ray or Gamma Dose for Period; and (7-1-98)

x. Neutron Dose for Period; and (7-1-98)

xi. Total Dose for Period; and (7-1-98)

xii. Running Dose for Calendar Quarter; and (7-1-98)

xiii. Total Lifetime Accumulated Dose. (7-1-98)

b. The doses entered in the forms or records required above must be for periods of time not exceeding one (1) calendar quarter. (7-1-98)

c. Each registrant shall maintain records in the same units used in Section 100 showing the results of surveys required by Subsection 120.01. (7-1-98)

d. Records of individual exposure to radiation which must be maintained pursuant to Subsection 140.01.a. must be preserved indefinitely or until the Radiation Control Agency authorizes their disposal. (7-1-98)

e. The discontinuance of or curtailment of activities, does not relieve the registrant of responsibility for retaining all records required by this Section. A registrant can, however, request the Radiation Control Agency to accept such records. Acceptance of the records by the Radiation Control Agency relieves the or registrant of subsequent responsibility only in respect to their preservation as required by this Section. (7-1-98)

f. Records of the results of surveys and monitoring which must be maintained pursuant to Subsection 140.01.c. must be preserved for two (2) years after completion of the survey except that the following records may be maintained until the Agency authorized their disposition: (7-1-98)

i. Records of the results of surveys to determine compliance with Subsection 110.03; and (7-1-98)

ii. In the absence of personnel monitoring data, records of the results of surveys to determine external radiation dose; and (7-1-98)

g. Records which must be maintained pursuant to this part may be the original or a reproduced copy or microform if such reproduced copy or microform is duly authenticated by authorized personnel and the microform is capable of producing a clear and legible copy after storage for the period specified by Agency rules. (7-1-98)

h. If there is a conflict between the Agency's rules in this part, registration, or other written Agency approval or authorization pertaining to the retention period for the same type of record, the retention period specified in the rules in this part for such records will apply unless the Agency, ~~*pursuant to*~~ under Section 0~~*06*~~15 of ~~*this chapter*~~ these rules, has granted a specific exemption from the record retention requirements specified in the rules in this part.
~~*(7-1-98)*~~(____)

02. Report of Theft or Loss of Sources of Radiation. Each licensee or registrant must report by telephone to the Radiation Control Agency the theft or loss of any source of radiation immediately after such occurrence becomes known. (7-1-98)

03. Notification of Incidents. (7-1-98)

a. Each registrant must immediately notify the Radiation Control Agency by telephone of any incident involving any radiation machine possessed by him and which may have caused or threatens to cause: (7-1-98)

i. A dose to the whole body of any individual of twenty-five (25) rems or more of radiation; a dose to the skin of the whole body of any individual of one hundred fifty (150) rem or more of radiation; or a dose to the feet, ankles, hands, or forearms of any individual of three hundred seventy-five (375) rems or more of radiation; or (7-1-98)

b. Each registrant must, within twenty-four (24) hours, notify the Radiation Control Agency by telephone of any incident involving any source of radiation possessed by him and which may have caused or threatens to cause: (7-1-98)

i. A dose to the whole body of any individual of five (5) rem or more of radiation; a dose to the skin of the whole body of any individual of thirty (30) rem or more of radiation; or a dose to the feet, ankles, hands, or forearms of seventy-five (75) rems or more of radiation; or (7-1-98)

c. Any report filed with the Radiation Control Agency pursuant to this Section must be prepared in such a manner that names of individuals who have received exposure to radiation will be stated in a separate part of the report. (7-1-98)

d. Details of any report filed with the Radiation Control Agency pursuant to this Section will be held confidential except as necessary for protection of the public health and to prevent accidental overexposure of individuals. (7-1-98)

04. Reports of Overexposure and Excessive Levels and Concentration. (7-1-98)

a. In addition to any notification required by Subsection 140.03, each registrant must make a report in writing within thirty (30) days to the Radiation Control Agency of: (7-1-98)

i. Each exposure of an individual to radiation in excess of any applicable limit as set forth in Section 100 or as otherwise approved by the Radiation Control Agency; and (7-1-98)

ii. Any incident for which notification is required by Subsection 140.03; and (7-1-98)

iii. Levels of radiation whether or not involving excessive exposure of any individual, in an unrestricted area in excess of ten (10) times any applicable limit as set forth in Section 100 or as otherwise approved by the Radiation Control Agency. Each report required under Subsection 140.04 must describe the extent of exposure of individuals to radiation, including estimates of each individual's exposure as required by Subsection 140.01.b.; levels of radiation; the cause of the exposure, and corrective steps taken or planned to assure against a recurrence. (7-1-98)

b. Any report filed with the Radiation Control Agency pursuant to this Section must

include, for each individual exposed, the name, social security number, date of birth, and an estimate of the individual's exposure. The report must be prepared so that this information is stated in a separate part of the report. (7-1-98)

c. In any case where a registrant is required pursuant to the provisions of this Section to report to the Radiation Control Agency any exposure of an individual to radiation, the registrant must, not later than the making of such report to the Radiation Control Agency, also notify such individual of the nature and extent of exposure. Such notice must be in writing and must contain the following statement:

"This report is furnished to you under the provisions of the Radiation Control Agency rules entitled 'Idaho Radiation Control Rules,' IDAPA 16, Title 02, Chapter 27, Rules of the Department of Health and Welfare. You should preserve this report for future reference." (7-1-98)

d. Each report required under Subsection 140.04.d. shall describe the extent of exposures of individuals to radiation, levels of radiation involved, the cause of exposure, levels, and corrective steps taken or planned to assure against a recurrence. (7-1-98)

05. Notifications and Reports to Individuals. (7-1-98)

a. Requirements for notification and reports to individuals of exposure to radiation are specified in Subsection 450.04. (7-1-98)

b. When a registrant is required pursuant to Subsection 140.04 to report to the Radiation Control Agency any exposure of an individual to radiation, the registrant must also notify the individual. Such notice must be transmitted at a time not later than the transmittal to the Radiation Control Agency, and must comply with the provisions of Subsection 450.04.a. (7-1-98)

06. Records and Reports of Misadministrations. (7-1-98)

a. When a misadministration involves any therapy procedure, the registrant shall notify by telephone the Radiation Control Agency. The registrant shall also notify the referring physician of the affected patient and the patient or a responsible relative (or guardian). These notifications must be made within twenty-four (24) hours after the licensee discovers the misadministration. If the referring physician, patient, or the patient's responsible relative or guardian cannot be reached within twenty-four (24) hours, the registrant shall notify them as soon as practicable. The registrant is not required to notify the patient or the patient's responsible relative or guardian without first consulting the referring physician; however, the licensee shall not delay medical care for the patient because of this. (7-1-98)

b. Within fifteen (15) days after an initial therapy misadministration report to the Radiation Control Agency, the registrant shall report, in writing to the Radiation Control Agency and to the referring physician, and furnish a copy of the report to the patient or the patient's responsible relative (or guardian) if either was previously notified by the licensee under the provisions of Subsection 140.07.a. The written report must include the registrant's name; the referring physician's name; a brief description of the event; the effect on the patient; the action taken to prevent recurrence; whether the registrant informed the patient or the patient's responsible relative (or guardian), and if not, why not. The report must not include the patient's

name or other information that could lead to identification of the patient. (7-1-98)

c. When a misadministration involves a diagnostic procedure, the Radiation Safety Officer shall promptly investigate its cause, make a record for review, and retain the record as directed in Subsection 140.07. The registrant shall also notify the referring physician within fifteen (15) days if the misadministration involved the administration of a dosage five (5) fold different from the intended dosage. (7-1-98)

d. Each registrant shall retain a record of each misadministration for ten (10) years. The record must contain the names of all individuals involved in the event (including the physician, allied health personnel, the patient, and the patient's referring physician), the patient's social security number or identification number if one has been assigned, a brief description of the event, the effect on the patient, and the action taken, if any, to prevent recurrence. (7-1-98)

e. Aside from the notification requirement, nothing in this section affects any rights or duties of registrants and physicians in relation to each other, patients, or responsible relatives (or guardians). (7-1-98)

(BREAK IN CONTINUITY OF SECTIONS)

155. PRECAUTIONARY PROCEDURES IN RADIOGRAPHIC OPERATION.

01. Documents Required at Field Radiography Sites. Each registrant conducting industrial radiography at a temporary jobsite must have the following records available at that site for inspection by the Agency: (7-1-98)

a. Appropriate certificate of registration. (7-1-98)

b. Operating and emergency procedures; (7-1-98)

c. Applicable rules and regulations; (7-1-98)

d. Survey records required pursuant to Section 155 for the period of operation at the site; (7-1-98)

e. Daily pocket dosimeter records for the period of operation at the site; and (7-1-98)

f. The latest instrument calibration and leak test records for specific devices in use at the site. Acceptable records include tags or labels which are affixed to the device or survey meter. (7-1-98)

02. Security. During each radiographic operation, the radiographer or radiographer's assistant must maintain a direct surveillance of the operation to protect against unauthorized entry into a high radiation area, as defined in Section 0~~02~~11 of these rules, except: ~~(7-1-98)~~( )

a. Where the high radiation area is equipped with a control device or alarm system as described in Subsection 120.03; or (7-1-98)

b. Where the high radiation area is locked to protect against unauthorized or accidental entry. (7-1-98)

03. Posting. Notwithstanding any provisions in Subsection 120.04.c., areas in which radiography is being performed must be conspicuously posted as required by Subsections 120.03.b. and 120.02.c.i. (7-1-98)

04. Radiation Surveys and Survey Records. (7-1-98)

a. No radiographic operation will be conducted unless calibrated and operable radiation survey instrumentation, as described in Subsection 153.04, is available and used at each site where radiographic exposures are made. (7-1-98)

b. Records must be kept of the surveys required by Subsection 155.04.c. and maintained for inspection by the Radiation Control Agency for two (2) years after completion of the surveys. (7-1-98)

c. A physical radiation survey must be made after each radiographic exposure using radiation machines to determine that the machine is "off." (7-1-98)

05. Special Requirements and Exemptions for Enclosed Radiography. (7-1-98)

a. Systems for enclosed radiography designed to allow admittance of individuals must: (7-1-98)

i. Comply with all applicable requirements of this part and Subsection 110.04. If such a system is a certified cabinet x-ray system, it must comply with all applicable requirements of this part and 21 CFR 1020.40. (7-1-98)

ii. Be evaluated at intervals not to exceed one (1) year to assure compliance with the applicable requirements as specified in Subsection 155.05.a. Records of these evaluations must be maintained for inspection by the Radiation Control Agency for a period of two (2) years after the evaluation. (7-1-98)

b. Certified cabinet x-ray systems designed to exclude individuals are exempt from the requirements of this part except that: (7-1-98)

i. Operating personnel must be provided with either a film badge or a thermoluminescent dosimeter, and reports of the results must be maintained for inspection by the Radiation Control Agency. (7-1-98)

ii. No registrant may permit any individual to operate a cabinet x-ray system until such individual has received a copy of and instruction in the operating procedures for the unit and has demonstrated competence in its use. Records which demonstrate compliance with this Subsection must be maintained for inspection by the Radiation Control Agency until disposition

is authorized by the Radiation Control Agency. (7-1-98)

iii. Tests for proper operation of high radiation area control devices or alarm systems, where applicable, must be conducted, recorded, and maintained in accordance with Subsection 153.09. (7-1-98)

iv. The registrant must perform an evaluation, at intervals not to exceed one (1) year, to determine conformance with Subsection 110.04. If such a system is a certified cabinet x-ray system, it must be evaluated at intervals not to exceed one (1) year to determine conformance with 21 CFR 1020.40. Records of these evaluations must be maintained for inspection by the Radiation Control Agency for a period of two (2) years after the evaluation. (7-1-98)

c. Certified cabinet x-ray systems must be maintained in compliance with 21 CFR 1020.40 unless prior approval has been granted by the Radiation Control Agency ~~*pursuant to*~~ under Section 0~~*06*~~15 of these rules. ~~*(7-1-98)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

203. GENERAL REQUIREMENTS.
The following general requirements must be followed in the use of x-rays in the healing arts. (7-1-98)

01. Administrative Controls. (7-1-98)

a. The registrant will be responsible for directing the operation of the x-ray machines which have been registered with the Radiation Control Agency under Subsection 090.01. Such persons or designated agents will assure that the following provisions are met in the operation of the x-ray machine(s): (7-1-98)

i. An x-ray machine which does not meet the provisions of these rules must not be operated for diagnostic or therapeutic purposes, if so directed by the Radiation Control Agency; and (7-1-98)

ii. Individuals who will be operating the x-ray equipment must be adequately instructed in the safe operating procedures and be competent in the safe use of the equipment. (7-1-98)

b. In the vicinity of each x-ray system's control panel a chart must be provided which specifies, for all examinations which are performed by that system, a listing of current information, including but not limited to the following, for each projection within that examination: (7-1-98)

i. Patient's anatomical size versus technique factors to be utilized; (7-1-98)

ii. Type and size of the film or film-screen combination to be used; (7-1-98)

iii. Type of grid to be used if any, and focal distance; (7-1-98)

iv. Source to image receptor distance to be used; and (7-1-98)

v. Type and location of placement of gonadal shielding to be used. (7-1-98)

c. Written safety procedures and rules will be provided to each individual operating x-ray equipment under the registrant's control; such procedures and rules will include any restrictions of the operating technique required for the safe operating of the particular x-ray system. The operator must be able to demonstrate familiarity with these rules. (7-1-98)

d. Except for patients who cannot be moved out of the room, only the staff and ancillary personnel required for the medical procedure or training can be in the room during the radiographic exposure. For all persons other than the patient being examined, the following must be observed: (7-1-98)

i. All individuals will be positioned such that no part of the body, including the extremities not protected by five tenths (0.5) mm lead equivalent, will be struck by the useful beam; (7-1-98)

ii. Staff and ancillary personnel must be protected from the direct scatter radiation by protective aprons or whole body protective barriers of not less than twenty-five hundredths (0.25) mm lead equivalent; (7-1-98)

iii. Patients who cannot be removed from the room will be protected from the direct scatter radiation by whole body protective barriers of twenty-five hundredths (0.25) mm lead equivalent or will be positioned such that the nearest portion of the body is at least two (2) meters from both the tube head and the nearest edge of the image receptor; and (7-1-98)

iv. When a portion of the body of any staff or ancillary personnel is potentially subjected to stray radiation which could result in that individual receiving one-quarter (1/4) of the maximum permissible dose, as defined in Section 100 additional protective devices can be required by the Radiation Control Agency. (7-1-98)

e. Gonadal shielding of not less than five-tenths (0.5) mm lead equivalent must be used for patients who have not passed the productive age of eighteen (18) to forty five (45) during radiographic procedures in which the gonads are in the direct (useful) beam, except for cases where this would interfere with the diagnostic procedure. (7-1-98)

f. Persons must not be exposed to the useful beam except for healing arts purposes, each exposure of which has been authorized by a licensed practitioner of the healing arts. Deliberate exposure for the following purposes is specifically prohibited: (7-1-98)

i. Exposure of an individual for training, demonstration or other purposes, unless there are also healing arts requirements and proper prescription has been provided; and (7-1-98)

ii. Exposure of an individual for the purpose of healing arts screening without prior

written approval of the Radiation Control Agency. Screening for this purpose will mean an exposure of a person without a prior examination by a licensed practitioner. (7-1-98)

g. When a patient or film must be provided with auxiliary support during a radiation exposure: (7-1-98)

i. Mechanical holding devices will be used when the technique permits. The safety rules required by Subsection 203.01.c. will list individual projections where holding devices cannot be utilized; (7-1-98)

ii. Written safety procedures, as required by Subsection 203.01.c., will indicate the requirements for selecting a human holder and the procedure the holder will follow; (7-1-98)

iii. The human holder will be protected as required by Subsection 203.01.d.; (7-1-98)

iv. No person can be used routinely to hold film or patients; (7-1-98)

v. A record must be made of the examination and must include the name of the human holder, date of the examination, number of exposures and technique factors utilized for the exposure(s); and (7-1-98)

vi. In those cases where the patient must hold the film, except during intraoral examinations, any portion of the body other than the area of clinical interest struck by the useful beam must be protected by not less than five-tenths (0.5) mm lead equivalent material. (7-1-98)

h. Procedures and auxiliary equipment designed to minimize patient and personnel exposure commensurate with the needed diagnostic information must be utilized. This includes but is not limited to: (7-1-98)

i. The speed of film or screen and film combinations, using the fastest speed consistent with the diagnostic objective of the examinations; (7-1-98)

ii. Using the minimum radiation exposure to the patient required to produce images of good diagnostic quality; and (7-1-98)

iii. Portable or mobile equipment only for examinations where it is impractical to transfer patients to a stationary radiographic installation. (7-1-98)

i. Regarding personnel monitoring, all persons who are associated with the operation of an x-ray system are subject to the occupational exposure limits and the requirements for the determination of the doses as stated in Section 100. In addition, the following requirements apply: (7-1-98)

i. When protective clothing or other devices are worn on portions of the body and when a monitoring device is required, at least one (1) such device must be worn at the collar outside of the protective clothing. The dose to the whole body based on the maximum dose attributed to any one (1) critical organ, which includes the gonads, blood forming organs, head and trunk, or lens of the eye, must be recorded in the reports required by Subsection 140.01. If

more than one (1) device is used and a record is made of the data, each dose must be identified with the area where the device was worn on the body; and (7-1-98)

ii. Exposure of a personnel monitoring device to deceptively indicate a dose delivered to an individual is prohibited. (7-1-98)

j. Any person proposing to conduct a healing arts screening program must not initiate such a program without prior approval of the Radiation Control Agency. When requesting such approval, that person must submit the information outlined in the following Subsections. If any information submitted to the Radiation Control Agency becomes invalid or outdated, the Agency must be immediately notified. Persons requesting that the Radiation Control Agency approve a healing arts screening program must submit the following information and evaluations: (7-1-98)

i. Name and address of the applicant and, where applicable, the names and addresses of agents within this State. (7-1-98)

ii. Diseases or conditions for which the x-ray examinations are to be used in diagnoses. (7-1-98)

iii. A detailed description of the x-ray examinations proposed in the screening program. (7-1-98)

iv. Description of the population to be examined in the screening program, i.e., age, sex, physical condition, and other appropriate information. (7-1-98)

v. An evaluation of any known alternate methods not involving ionizing radiation which could achieve the goals of the screening program and why these methods are not used instead of the x-ray examinations. (7-1-98)

vi. An evaluation by a qualified expert of the x-ray system(s) to be used in the screening program. The evaluation by the qualified expert must show that such system(s) do satisfy all requirements of these rules. (7-1-98)

vii. A description of the diagnostic film quality control program. (7-1-98)

viii. A copy of the technique chart for the x-ray examination procedures to be used. (7-1-98)

ix. The qualifications of each individual who will be operating the x-ray system(s). (7-1-98)

x. The qualifications of the individual who will be supervising the operators of the x-ray system(s). The extent of supervision and the method of work performance evaluation must be specified. (7-1-98)

xi. The name and address of the individual who will interpret the radiograph(s). (7-1-98)

xii. A description of the procedures to be used in advising the individuals screened and their private practitioners of the healing arts of the results of the screening procedure and any further medical needs indicated. (7-1-98)

xiii. A description of the procedures for the retention or disposition of the radiographs and other records pertaining to the x-ray examinations. (7-1-98)

02. Exemptions. The Radiation Control Agency can waive compliance with the specific requirements of Section 203 for an existing machine or installation if: (7-1-98)

a. Such compliance would require replacement or substantial modification of the machine or installation; and (7-1-98)

b. The registrant demonstrates to the Radiation Control Agency's satisfaction, achievement through other means of radiation protection equivalent to that required by these rules. (7-1-98)

03. Structural Shielding. Each installation must be provided with primary barriers ~~*and/*~~or secondary barriers as necessary to assure compliance with Subsections 110.01 and 110.04. This requirement will be deemed to be met if the thicknesses of such barriers are equivalent to those as computed in accordance with National Council of Radiation Protection Report No. ~~*49*~~147, ~~*(or it's successor)*~~ entitled: "Structural Shielding Design and Evaluation for Medical Use of X-rays and Gamma Rays of Energies up to Ten (10) MeV," ~~*which*~~ issued November 19, 2004, by the National Council on Radiation Protection and Measurement. This document may be obtained from NCRP Publications, 7910 Woodmont, Bethesda, MD 20814. ~~*(7-1-98)*~~(____)

04. Minimum Design Requirements for an X-ray Machine Operator's Booth. (7-1-98)

a. The operator will be allotted not less than seven and five-tenths (7.5) square feet of unobstructed floor space in the booth. The booth must protect the operator from the useful beam and from any radiation which has been scattered only once. (7-1-98)

i. The minimum space, as indicated above, can be any geometric configuration but with no dimension less than two (2) feet. (7-1-98)

ii. The space allotted will not include any encumbrance by the console, such as overhang, cable, or other similar encroachments. (7-1-98)

iii. The booth must be located or constructed such that unattenuated direct scatter radiation originating on the examination table or at the wall cassette does not reach the operator's station in the booth. (7-1-98)

iv. The booth walls must be at least seven (7) feet high and must be permanently fixed to the floor or other structure. (7-1-98)

v. When a door or movable panel is used as an integral part of the booth structure, it

must have a permissive device which prevents an exposure when the door or panel is not closed. (7-1-98)

b. The operator's switch for the radiographic machine will be fixed within the booth and: (7-1-98)

i. Must be at least forty (40) inches from any open edge of the booth wall which is proximal to the examining table; and (7-1-98)

ii. Must allow the operator to use the majority of the available viewing window. (7-1-98)

c. Viewing system requirements: (7-1-98)

i. Each booth must have at least one (1) viewing device which will: (7-1-98)

(1) Be so placed that the operator can view the patient during any exposure; and (7-1-98)

(2) Be so placed that the operator can have full view of any occupant of the room and can view any entry into the room. If any door which allows access to the room cannot be seen from the booth, then that door must have a permissive device controlling the exposure which will prevent exposure if the door is not closed. (7-1-98)

ii. If the viewing system is a window, the following requirements also apply: (7-1-98)

(1) The window must have a visible area of at least one (1) square foot~~*, the center of which is five (5) feet above the floor*~~; and ~~*(7-1-98)*~~(____)

(2) The window materials must have at least the same lead equivalence as that required in the booth's wall in which it is to be mounted. (7-1-98)

iii. When the viewing system utilizes one (1) or more mirrors, the mirrors must be so located as to accomplish the general requirements as in Subsection 203.04.c.i. (7-1-98)

iv. When the viewing system utilizes electronic means, such as a television: (7-1-98)

(1) The camera must be so located as to accomplish the general requirements in Subsection 203.04.c.i.; and (7-1-98)

(2) There must be an alternate viewing system to serve as a back-up in case of electronic failure. (7-1-98)

(BREAK IN CONTINUITY OF SECTIONS)

211. RADIOGRAPHIC MACHINES USED FOR MAMMOGRAPHY.
In addition to other applicable requirements of these rules, radiation machines used for mammography shall comply with these requirements: (7-1-98)

01. General Requirements. (7-1-98)

a. Only radiation machines specifically designed for mammography shall be used; (7-1-98)

b. Radiation machines used for mammography shall be evaluated to ensure conformance to the requirements of these rules at intervals not to exceed twelve (12) months, and upon installation prior to being used on human beings. (7-1-98)

c. The registrant shall record the results of all tests made to evaluate compliance with these rules, and shall maintain these records available for inspection by the agency for a minimum of three (3) years. (7-1-98)

02. Radiation Machine Standards. (7-1-98)

a. X-ray Beam Quality. (7-1-98)

i. When used with screen-film image receptors, the useful beam shall have a half-value layer (HVL) between the values of: measured kilovoltage/100 and measured kilovoltage/ 100 + 0.1 millimeters aluminum equivalent. (7-1-98)

ii. All other mammography imaging modalities shall meet the requirements for minimum half-value layer specified in Subsection 204.03.a. of these rules. (7-1-98)

iii. Determination of half-value layer for mammography systems shall include the contribution to useful beam equivalent aluminum filtration made by the compression device. (7-1-98)

iv. The actual kilovolts-peak (kVp) shall be within plus or minus five percent (5%) of the indicated kVp. (7-1-98)

b. Radiation Output. (7-1-98)

i. Radiation machines used for mammography shall be capable of producing five hundred (500) milliroentgens/ second (one hundred twenty nine (129) microCoulomb/kilogram/ second) for at least three (3) seconds, and producing a minimum output of eight (8) milliroentgens (two point one (2.1) microCoulomb/kilogram) per milliAmpere-second. (7-1-98)

ii. The minimum radiation output requirements of this part shall be measured at a point four point five (4.5) centimeters from the surface of the patient support device with the source-to-image receptor distance (SID) at maximum and the output attenuation of the compression device included. (7-1-98)

c. X-ray Beam Alignment/Limitation/Transmission. (7-1-98)

i. The radiation machine used for mammography shall be provided with means to limit the useful x- ray beam so that the x-ray field at the plane of the image receptor does not extend beyond any edge of the image receptor at any designated source to image receptor distance except the edge of the image receptor adjacent to the chest wall, where the x-ray field may extend beyond this edge by no more than two percent (2%) of the SID. (7-1-98)

ii. The projected collimator light field shall extend beyond the projected radiation field along both the length or width of the radiation field, at any designated source to image receptor distance, by no more than two percent (2%) of the SID. (7-1-98)

d. Mammographic Exposure Control. (7-1-98)

i. Radiation machines used for mammography shall incorporate means to terminate the exposure at a preset time interval, a preset product of tube current and exposure duration, a preset number of pulses, or a preset radiation exposure at the plane of the image receptor.(7-1-98)

ii. Exposure shall only be possible by the use of an exposure switch of the "deadman" type as defined in Subsection ~~*002.30*~~ 010.21 of these rules. ~~*(7-1-98)*~~( )

iii. When both manual and automatic exposure control modes are available, the x-ray control panel shall clearly indicate which mode is selected. (7-1-98)

iv. The coefficient of variation between exposures for both automatic and manual exposure modes shall not exceed five one hundredth (0.05). This requirement is met when four (4) successive exposures are made at identical exposure factors, and the standard devation of the four (4) exposure values divided by the mean exposure value is less than or equal to five one hundredth (0.05). (7-1-98)

v. Exposure control in the automatic exposure mode shall provide the capability of maintaining constant film density to within plus or minus three tenths (0.3) optical density unit of the average optical density over the range of clinically used kilovoltage, for acrylic or BR-12 phantom thicknesses of two (2) centimeters to six (6) centimeters. (7-1-98)

vi. The mammography exposure control system(s) shall limit the mean glandular dose, for one craniocaudal view of a four point five (4.5) centimeter compressed breast composed of fifty percent (50%) adipose fifty percent (50%) glandular tissue, not to exceed these values: (7-1-98)

(1) One (1) milligray (one hundred (100) millirads) for non-grid screen-film imaging modes; (7-1-98)

(2) Three (3) milligray (three hundred (300) millirads) for screen-film systems with grid. (7-1-98)

(3) The technical exposure factors used to determine compliance with this part shall be those used by the facility for its clinical images of a fifty percent (50%) adipose fifty percent (50%) glandular tissue four point five (4.5) centimeter compressed breast, craniocaudal view.

(7-1-98)

vii. Determination of mean glandular dose shall be made with a breast phantom in the useful beam. The breast phantom shall be equivalent in attenuation to the RMI 156 breast phantom. (7-1-98)

e. Integral Ancillary Equipment. (7-1-98)

i. Radiation machines used for mammography shall be provided with an integral anti-scatter grid available for use with all image receptor sizes. (7-1-98)

ii. The mammography radiation machine shall be provided with a compression device which is capable of compressing the breast with a force of at least twenty five (25) pounds and no more than forty (40) pounds for a period of at least fifteen (15) seconds. (7-1-98)

iii. The chest wall edge of the compression paddle must be aligned with the chest wall edge of the image receptor to within one percent (1%) of the SID when the compression paddle is placed four point five (4.5) centimeters above the patient support device. (7-1-98)

iv. Radiation machines used for mammography, and which are newly installed after the effective date of these rules shall incorporate a post-exposure milliampere-seconds indicator when used in automatic exposure control mode. (7-1-98)

03. Quality Assurance Program. (7-1-98)

a. QA Program Responsibilities. The registrant shall maintain, and have in place prior to the initiation of mammography imaging, a written quality assurance program for each mammography x-ray system. The registrant shall be responsible for providing qualified individuals whose duties include: (7-1-98)

i. Conducting equipment performance monitoring functions; (7-1-98)

ii. Analyzing the monitoring results to determine if there are problems requiring correction; (7-1-98)

iii. Carrying out or arranging for the necessary corrective actions when quality assurance testing indicates a standard in these rules is not met. (7-1-98)

b. Image Quality Standards/Processor Performance. (7-1-98)

i. Phantom Image Quality. The mammography x-ray system shall be capable of providing an image of a seventy five one hundredths (0.75) millimeter fiber, a thirty two one hundredths (0.32) millimeter speck group, and a seventy five one hundredths (0.75) millimeter mass. This standard will be met when a mammographic image of an RMI 156 breast phantom demonstrates four (4) fibers, three (3) speck groups and three (3) masses. (7-1-98)

ii. Mid-density (MD) density difference (DD). Deviations from established operating levels for measured values of mid-density (MD) and density difference (DD) on sensitometric

control charts shall not exceed one tenth (0.10) Optical Density Units. (7-1-98)

iii. Base + Fog (B + F). The base + fog shall not exceed the established operating level by more than three one hundredths (0.03) Optical Density Units. (7-1-98)

iv. Darkroom Fog. Darkroom fog levels shall not exceed five one hundreths (0.05) Optical Density Units above base + fog. Darkroom fog tests shall be made with film presensitized by exposure to sufficient light from an intensifying screen so that after processing, an Optical Density of one and two tenths (1.2) to one and six tenths (1.6) is achieved. The presensitized film shall be exposed to darkroom safelight conditions for two (2) minutes. (7-1-98)

v. Image Receptor Systems. Image receptor systems and their individual components shall be specifically designed for, and appropriate to mammography imaging. (7-1-98)

vi. Intensifying Screens. Mammography image intensifying screens shall be removed from service and appropriate corrective action implemented if the following standards are not met: (7-1-98)

(1) Screen Speed Uniformity. Intercomparison of the measured optical density in the geometric center of a phantom image obtained with each intensifying screen in use shall be not exceed three tenths (.3) optical density unit between the minimum and maximum density. The technical exposure factors shall be the same for each screen, and the phantom used for these images shall be a four (4) centimeter thick cassette-sized phantom of acrylic or BR-12, or a breast phantom equivalent in attenuation to the RMI 156. (7-1-98)

(2) Screen-film Contact. Cassettes shall not be used for mammography if one or more large areas (> = one (1.0) centimeters) of poor film-screen contact is visualized on an image made with a forty (40) mesh mammography film- screen contact test tool. (7-1-98)

(3) Screen Identification. Each intensifying screen shall be legibly marked with a unique identification mark for that particular screen, visible on the film outside the area of clinical interest, with a corresponding mark on the outside of the cassette. (7-1-98)

vii. Film Processors. Film processors utilized for mammography shall be adjusted to, and operated at the specifications recommended by the mammographic film manufacturer. Alternative settings which are shown by documented test results to provide equivalent sensitometric performance are acceptable. (7-1-98)

viii. Reject Rate. Corrective action shall be taken if the film reject rate exceeds five percent (5%). The reject rate shall be based upon clinical images which must be repeated. (7-1-98)

c. Quality Assurance Tests/Intervals. The registrant shall ensure that the following quality control tests are performed when applicable equipment or components are initially installed, replaced or repaired, and at least at these specified intervals: (7-1-98)

i. Primary Secondary Barrier Transmission -- Upon initial installation and following each significant modification to the mammography system or the primary secondary barriers.

(7-1-98)

ii. Processor performance by sensitometric means -- daily, or each day of use prior to the first patient exposure. For any mammography registrant using film processors at multiple locations, such as mobile mammography services, each processor shall be subject to this requirement. (7-1-98)

iii. Screen Cleanliness Artifacts -- weekly. (7-1-98)

iv. Image Quality -- monthly for stationary systems and prior to performing mammography at each location for mobile systems. (7-1-98)

v. Reject Rate Analysis -- three (3) months. (7-1-98)

vi. Compression Device -- six (6) months. (7-1-98)

vii. Darkroom Integrity (safelight condition, light leaks) -- six (6) months. (7-1-98)

viii. Screen-film Contact -- six (6) months. (7-1-98)

ix. Beam Alignment and Limitation -- twelve (12) months. (7-1-98)

x. Automatic Exposure Control Reproducibility -- twelve (12) months. (7-1-98)

xi. Collimator alignment -- twelve (12) months. (7-1-98)

xii. Focal Spot Size Resolution -- upon initiation installation and at each tube replacement, and at intervals not to exceed twelve (12) months. (7-1-98)

xiii. Half-value Layer -- twelve (12) months. (7-1-98)

xiv. kVp Accuracy -- twelve (12) months. (7-1-98)

xv. Radiation Output Reproducibility and Linearity -- twelve (12) months. (7-1-98)

d. QA Program Annual Review. In addition to the routine quality assurance testing required in these rules, the registrant shall effect a comprehensive review of the effectiveness of all elements of the quality assurance program for each mammography system at intervals not to exceed twelve (12) months. This review shall: (7-1-98)

i. Address all aspects of quality assurance in these rules for each mammography x-ray system; (7-1-98)

ii. Be documented in writing and the results maintained available for inspection by the agency for three (3) years; (7-1-98)

e. Corrective Action. When a mammography x-ray system fails one of the quality assurance tests required in these rules, unless otherwise specified herein, the mammography x-ray

system shall be removed from service until appropriate corrective action is completed. The mammography x-ray system shall not be placed back into service until repeat test results verify adequacy of the corrective action. (7-1-98)

212. -- 299. (RESERVED).

300. RADIATION SAFETY REQUIREMENTS FOR ANALYTICAL X-RAY OPERATIONS.
The rules in Section 300 establish requirements for the use of analytical x-ray machines, as defined in Subsection ~~002.10~~ 010.05 and ~~002.11~~ 010.06 by persons registering such machines under the provisions of Section 090. The provisions of Section 300 are in addition to, and not in substitution for, other applicable provisions of these rules. ~~(7-1-98)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

355. -- 4~~3~~49. (RESERVED).

~~***440. PUBLIC AND CONFIDENTIAL INFORMATION.***~~

~~***01. Accessibility**. Except as provided in this section or other applicable law, information obtained or submitted pursuant to these rules will be available to the public for inspection and copying during normal working hours. Anyone requesting Radiation Control Agency assistance in collecting, copying or mailing public information must tender, in advance, the reasonable cost of those services. (7-1-98)*~~

~~***02. Confidentiality**. Information concerning radiation sources submitted to the Radiation Control Agency pursuant to these rules which, as certified by the owner or operator of such source, relates to production or sales figures or to processed or production unique to the owner or operator, or tends to adversely affect the competitive position of such owner or operator, may be disclosed only to the Board, the Radiation Control Agency or a hearing officer unless: (7-1-98)*~~

~~***a.** The Board, after a hearing, determines that a claim of uniqueness or adverse effect is unwarranted; (7-1-98)*~~

~~***b.** The owner or operator expressly consents to disclosure; or (7-1-98)*~~

~~***c.** Disclosure is required for criminal prosecution of a violation of the Idaho Environmental Protection and Health Act. (7-1-98)*~~

~~***03. Department Discretion**. The Radiation Control Agency may decline to release to the public: (7-1-98)*~~

~~***a.** Inconclusive preliminary data or reports generated as part of ongoing studies; and (7-1-98)*~~

~~***b.*** *Information obtained as part of ongoing investigations when release would:* *(7-1-98)*~~

~~*i.* *Interfere with enforcement proceedings;* *(7-1-98)*~~

~~*ii.* *Deprive a person of a fair or impartial adjudication;* *(7-1-98)*~~

~~*iii.* *Discourage informants from disclosing information to the Radiation Control Agency;* *(7-1-98)*~~

~~*iv.* *Disclose investigative techniques or proceedings; or* *(7-1-98)*~~

~~*v.* *Endanger the safety of Radiation Control Agency personnel.* *(7-1-98)*~~

~~***441. -- 449. (RESERVED).***~~

(BREAK IN CONTINUITY OF SECTIONS)

451. -- 99~~5~~9. (RESERVED).

~~***996. ADMINISTRATIVE PROVISIONS.***~~
~~*Contested case appeals shall be governed by Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Sections 000., et seq., "Rules Governing Contested Case Proceedings and Declaratory Rulings."* *(7-1-98)*~~

~~***997. CONFIDENTIALITY OF RECORDS.***~~
~~*Any disclosure of information obtained by the Department is subject to the restrictions contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records."* *(7-1-98)*~~

~~***998. -- 999. (RESERVED).***~~

HOUSE HEALTH AND WELFARE COMMITTEE

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective dates 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 2008 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, 56-253, 56-255, and 56-257, Idaho Code; Section 1902 of the Social Security Act; and Section 405(c)(1) of the Tax Relief and Health Care Act of 2006 (TRHCA), P.L. 109-432.

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 the definition for "Newborn Deemed Eligible" and qualifying the circumstances of a mother's eligibility for Medicaid.

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 complete text of the proposed rule was published in the August 1, 2007, Idaho Administrative Bulletin, Vol. 07-8, pages 94 through 97.

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:

Based on data from the Eligibility Programs Integrated Computer System (EPICS) and the Division of Medicaid, approximately one hundred and sixty (160) newborn children will be added to Medicaid because of this rule change. The average Medicaid cost for a newborn child for one year is $5,202. This will result in a yearly increase in Medicaid spending of $832,320 of which $250,000 is general fund money.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions

concerning the pending rule, contact Linda Palmer at (208) 334-5845.

DATED this 20th day of September, 2007.

Sherri Kovach
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THE FOLLOWING NOTICE 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 regular 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, 56-253, 56-255, and 56-257, Idaho Code; Section 1902 of the Social Security Act; and Section 405(c)(1) of the Tax Relief and Health Care Act of 2006 (TRHCA), P.L. 109-432.

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 15, 2007.

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

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

The Department is making two changes to this chapter of rule as listed below:

1. **Because of recent changes made to Section 1902 of the Social Security Act, Centers for Medicare and Medicaid Services (CMS) has reversed a final policy ruling made**

in July of 2006. It will now deem a baby eligible for Medicaid coverage for his first year of life when the baby was born to a mother covered by emergency Medicaid. This policy change means that all babies born in the United States, whose deliveries are covered by Medicaid, receive the same coverage (i.e., Medicaid for one full year after birth).

2. **The Tax Relief and Health Care Act of 2006 (TRHCA) provided clarification to the Deficit Reduction Act of 2005 (DRA) through an amendment to the Social Security Act. Based on this clarification, two additional categories of people who are exempt from the Medicaid requirement to prove their U. S. citizenship and identity will be added to these rules. These groups are Social Security Disability Income (SSDI) recipients and foster care children receiving child welfare services under Title IV-B of the Social Security Act. They are considered exempt because either the Department or the Social Security Administration verifies citizenship and identity before they issue benefits.**

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 meet federal regulations.

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

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

Based on data from the Eligibility Programs Integrated Computer System (EPICS) and the Division of Medicaid, approximately one hundred and sixty newborn children will be added to Medicaid because of this rule change. The average Medicaid cost for a newborn child for one year is $5,202. This will result in a yearly increase in Medicaid spending of $832,320 of which $250,000 is general fund money.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking is being done to comply with federal regulation.

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 August 22, 2007.

DATED this 21st day of June, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

011. DEFINITIONS (M THROUGH Z).
For the purposes of these rules the following terms are used as defined below: (3-30-07)

01. **Newborn Deemed Eligible**. A child born to a woman *who is* eligible for and receiving medical assistance on the date of the child's birth. A child so born is eligible for Medicaid for the first year of his life. *(7-1-06)T( )*

0~~1~~2. **Participant**. A person eligible for, and enrolled in, the Idaho medical assistance program. (3-30-07)

0~~2~~3. **Premium**. A regular, periodic charge or payment for health coverage as set forth in IDAPA 16.03.16, "Premium Assistance." (3-30-07)

0~~3~~4. **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. (3-30-07)

0~~4~~5. **SSI**. Supplemental Security Income. (3-30-07)

0~~5~~6. **SSN**. Social Security Number. (3-30-07)

0~~6~~7. **State**. The state of Idaho. (3-30-07)

0~~7~~8. **TAFI**. Temporary Assistance for Families in Idaho. (3-30-07)

0~~8~~9. **TANF**. Temporary Assistance to Needy Families. (3-30-07)

~~09~~10. **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. (3-30-07)

1~~0~~1. **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. (3-30-07)

1~~1~~2. **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. (3-30-07)

1~~2~~3. **Working Day.** A calendar day in which the regular hours of Department activity

occur. Weekends and State holidays are not considered working days. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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:*~~ The individuals listed in Subsections 225.01 through 225.05 of this rule meet the U.S. citizenship and identity requirements and are not required to provide documentation of citizenship and identity. ~~*(3-30-07)*~~(____)

01. Supplemental Security Income (SSI) Recipients. (____)

02. Social Security Disability Income (SSDI) Recipients. (____)

03. Individuals Determined by SSA to Be Entitled to Receive Medicare. (____)

04. Adoptive or Foster Care Children Receiving Assistance Under Title IV-B or Title IV-E of the Social Security Act. (____)

226. ~~*TITLE IV-E FOSTER CARE CHILD*~~ (RESERVED).
~~*The Department will not deny or delay Medicaid for a child receiving Title IV-E Foster Care assistance pending citizenship and identity documentation.*~~ ~~*(3-30-07)*~~

(BREAK IN CONTINUITY OF SECTIONS)

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. (3-30-07)

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. (3-30-07)

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: (3-30-07)

a. Is a member of a recognized religious sect or division of the sect; and (3-30-07)

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. (3-30-07)

03. SSN Requirement Waived. An applicant may have the SSN requirement waived when he is: (3-30-07)

a. Only eligible for emergency medical services as described in Section 250 of these rules; or (3-30-07)

b. A ~~*waived*~~ newborn deemed eligible child as described in Section 530 of these rules. ~~*(3-30-07)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

530. NEWBORN CHILD DEEMED ELIGIBLE FOR MEDICAID.
~~*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.*~~ A child is deemed eligible for Medicaid for his first year of life if: ~~*(3-30-07)*~~(____)

01. Mother ~~***Under Title XIX***~~ **Filing an Application**. ~~*If the newborn's mother is receiving services under Title XIX at the time of the child's birth; or*~~ The child is born to a mother who files an application for medical assistance; and ~~*(3-30-07)*~~(____)

02. Mother ~~***Under Title XXI and Is at 133% to 150% of FPG***~~ **Is Eligible for Medicaid**. ~~*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.*~~ The mother is at or below one hundred thirty-three percent (133%) FPG and is eligible for Medicaid ~~*coverage of the delivery*~~. *This includes a mother with income at or below one hundred thirty-three percent (133%) of poverty who qualifies for coverage of only the delivery because of her alien status.*
~~*(3-30-07)*~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0702

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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, 56-253, 56-255, and 56-257, Idaho Code; 42 CFR, Part 435, 436, 440, 441, 457 and 483.

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 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 372 through 378.

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 to the state general fund related to this rulemaking.

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

DATED this 30th day of October, 2007.

Sherri Kovach,
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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0301-0702***
Eligibility for Health Care Assistance for Families and Children ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rules are July 13, 2007, and October 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, 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; 42 CFR, Part 435, 436, 440, 441, 457 and 483.

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 17, 2007.

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:

There are three rule changes in this docket as follows:

1. **Changes will be made in order to clarify the types of acceptable documentation for citizenship and identity requirements in the Deficit Reduction Act of 2005. (eff. 7/13/07)**
2. **Idaho's Medicaid rules need to be aligned with federal regulations regarding the effective dates for requesting continued benefits pending a fair hearing decision. When a participant disagrees with an eligibility decision, he has a right to request continued benefits pending the fair hearing. Per federal regulations, the participant has until the effective date of the action taken on their case to request continued benefits. Currently, Idaho rule allows continued benefits when a request is made within ten (10) days of the mailing of the notice of decision. Aligning Idaho's rules may give the participant additional time to request continued benefits. (eff. 10/1/07)**
3. **A portion of the Federal requirements for Transitional Medicaid reporting were taken out of rule in error last year during the Medicaid Reform rewrite. Idaho rules must be updated to include the Transitional Medicaid reporting time lines and requirements for continuing Transitional Medicaid. (eff. 10/1/07)**

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 being done to meet federal regulations and the rules confer a benefit to the participants.

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

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

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking is being done to comply with federal regulation.

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 October 24, 2007.

DATED this 21st day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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: (3-30-07)

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. (3-30-07)

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." (3-30-07)

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 request~~s~~ for the ~~*hearing and for the*~~ reinstatement ~~*are*~~ is made ~~*within ten (10) days of the mailing of the notice of action*~~ before the effective date of the action taken on the notice of decision. ~~*(3-30-07)*~~(____)

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. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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: (3-30-07)

a. A U.S. passport; (3-30-07)

b. A Certificate of Naturalization, DHS Forms N-550 or N-570; or (3-30-07)

c. A Certificate of U.S. Citizenship, DHS Forms N-560 or N-561. (3-30-07)

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. (3-30-07)

a. A U.S. birth certificate that shows the individual was born in one (1) of the following: (3-30-07)

i. United States fifty (50) states; (3-30-07)

ii. District of Columbia; (3-30-07)

iii. Puerto Rico, on or after January 13, 1941; (3-30-07)

iv. Guam, on or after April 10, 1899; (3-30-07)

v. U.S. Virgin Islands, on or after January 17, 1917, (3-30-07)

vi. America Samoa; (3-30-07)

vii. Swain's Island; or (3-30-07)

viii. Northern Mariana Islands, after November 4, 1986; (3-30-07)

b. A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545; (3-30-07)

c. A report of birth abroad of a U.S. Citizen, Form FS 240; (3-30-07)

d. A U.S. Citizen I.D. card, DHS Form I-197; (3-30-07)

e. A Northern Mariana Identification Card, Form I-873; (3-30-07)

f. An American Indian Card issued by the Department of Homeland Security with the classification code "KIC," Form I-873; (3-30-07)

g. A final adoption decree showing the child's name and U.S. place of birth; (3-30-07)

h. Evidence of U.S. Civil Service employment before June 1, 1976; ~~*or*~~ ~~*(3-30-07)*~~(____)

i. An official U.S. Military record showing a U.S. place of birth~~.~~; ~~*(3-30-07)*~~(____)

j. Certification of birth abroad, Form FS-545; (____)

k. Verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database; or (____)

l. Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000. (____)

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. (3-30-07)

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 (3-30-07)

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. (3-30-07)

c. Religious record recorded in the U.S. within three (3) months of birth showing the birth occurred in the U.S. and showing whether the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. (____)

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. (3-30-07)

a. Federal or state census record that shows the individual has U.S. citizenship or a U.S. place of birth; (3-30-07)

b. One (1) of the following documents that shows a U.S. place of birth for participants sixteen (16) years of age or older and was created at least five (5) years before the application for Medicaid. For children under sixteen (16) years of age, the document must have been created near the time of birth; ~~(3-30-07)~~(____)

i. Seneca Indian tribal census record; (3-30-07)

ii. Bureau of Indian Affairs tribal census records of the Navajo Indians; (3-30-07)

iii. U.S. State vital Statistics official notification of birth registration; (3-30-07)

iv. A~~*n amended*~~ delayed U.S. public birth record that is ~~*amended*~~ recorded more than five (5) years after the person's birth; ~~(3-30-07)~~(____)

v. Statement signed by the physician or midwife who was in attendance at the time of birth; (3-30-07)

vi. Medical (clinic, doctor, or hospital) record; (3-30-07)

vii. Institutional admission papers from a nursing facility, skilled care facility or other institution; or (3-30-07)

viii. Bureau of Indian Affairs roll of Alaska Natives. (____)

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 for proof of U.S. citizenship or naturalization if no other documentation is available and complies with the following: ~~(3-30-07)~~(____)

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; (3-30-07)

ii. One (1) of the persons making a declaration cannot be related to the individual claiming U.S. citizenship; (3-30-07)

~~*iii. Neither of the two (2) persons making the declaration can be an applicant or recipient of Medicaid;*~~ ~~*(3-30-07)*~~

i~~v~~ii. The persons making the declaration must provide proof of their own U.S. citizenship and identity; and (3-30-07)

~~*v. The persons making the declaration must provide an explanation as to why documentation for the individual does not exist or cannot be obtained.*~~ ~~*(3-30-07)*~~

~~v~~iv. 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. (3-30-07)

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. (3-30-07)

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; (3-30-07)

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; (3-30-07)

c. School identification card with a photograph of the individual; (3-30-07)

d. U.S. Military card or draft record; (3-30-07)

e. Military dependent's identification card; (3-30-07)

f. U. S. Coast Guard Merchant Mariner card; (3-30-07)

g. Certificate of Degree of Indian blood; or (3-30-07)

h. Native American Indian or Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. (3-30-07)

i. Identity affidavits are acceptable proof of identity for individuals living in a residential care facility. ( )

(BREAK IN CONTINUITY OF SECTIONS)

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.*~~ Individuals and families who were eligible for Title XIX Medicaid coverage under the AFDC-related coverage groups are eligible for Transitional Medicaid if the family income exceeds limits because of a reason listed in Subsections 421.01 through 421.03 of this rule. The family 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 meets the condition in Subsection 421.01 of this rule. Eligible families may

receive Transitional Medicaid for up to twelve (12) months. ~~*(3-30-07)*~~(____)

01. ~~***Employment Income Increased****. Family income exceeds limits because employment income increased.*~~ **Idaho TAFI Income and Income from Employment**. Family income exceeds limits because they have Idaho TAFI income and income from employment. ~~*(3-30-07)*~~(____)

02. ~~***Disregard Expired****. Family income exceeds limits because the thirty dollar ($30) plus one-third (1/3) or the thirty dollar ($30) disregard expired.*~~ **Employment Income Increased**. Family income exceeds limits because employment income increased. ~~*(3-30-07)*~~(____)

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

422. TRANSITIONAL MEDICAID NOTICE REQUIREMENTS.
The participant must be provided notice during Transitional Medicaid as described in Subsections 422.01 and 422.02. (____)

01. **Required Notice During First Six Months of Transitional Medicaid**. The Department will notify the participant of the reporting requirements and the option for months seven (7) through twelve (12) of Transitional Medicaid. The Department will send the notice and the report form in month three (3) and month six (6) of Transitional Medicaid. (____)

02. **Required Notice During Second Six Months of Transitional Medicaid**. The Department will notify the participant of reporting requirements. The Department will send the notice and the report form in month nine (9) of TM. (____)

423. TRANSITIONAL MEDICAID REPORTING REQUIREMENT.
Families receiving Transitional Medicaid are mailed three (3) report forms during the twelve (12) Transitional Medicaid months. Families must complete and return the reports as listed in Subsections 423.01 through 423.03. (____)

01. **First Report**. The family must complete and return the report only if changes have occurred in earnings, household composition or work-related child care costs. The first report is due by day twenty-one (21) of TM month four (4). The report covers TM months one (1) through three (3). (____)

02. **Second Report**. The family must complete and return the report only if changes have occurred in earnings, household composition or work-related child care costs. The second report is due by day twenty-one (21) of TM month seven (7). The report covers TM months four (4) through six (6). (____)

03. **Third Report**. The family must complete and return the report only if changes have occurred in earnings, household composition or work-related child care costs. The third report is due by day twenty-one (21) of Transitional Medicaid month ten (10). The report covers Transitional Medicaid months seven (7) through nine (9). (____)

424. INCOME TESTS FOR TRANSITIONAL MEDICAID.

When a family reports changes in earnings, household composition or child care costs, eligibility to receive months seven (7) through twelve (12) of Transitional Medicaid must be evaluated using the income tests listed in Section 424. Use the steps in Table 424.01 for the first income test, done at the end of month seven (7) of Transitional Medicaid. Use steps in Table 424.02 for the second income test, done at the end of month ten (10) of Transitional Medicaid. ( )

01. First Transitional Medicaid Income, Test Done at the End of Month Seven.

TABLE 424.01 - FIRST TRANSITIONAL MEDICAID INCOME TEST, DONE AT THE END OF MONTH SEVEN (7)	
STEP	**ACTION**
Step 1.	Add the gross monthly earnings from months four (4) through six (6) of Transitional Medicaid.
Step 2.	Subtract allowable child care costs from months four (4) through six (6) of Transitional Medicaid from the total gross earnings. Allowable child care costs are costs necessary for the employment of the caretaker relative, not paid by another party.
Step 3.	Divide the result of the computation in Step 2 by three (3). The result is the average monthly earnings.
Step 4.	Select the Federal Poverty Guideline amount for the family size and multiply that amount by one hundred eighty-five percent (185%).
Step 5.	Compare the average monthly earnings from Step 3 with the product of Step 4. If the average monthly earnings in Step 3 exceed the amount computed in Step 4, close Transitional Medicaid. Adequate notice is required.

( )

02. Second Transitional Medicaid Income Test, Done at the End of Month Ten.

TABLE 424.02 - SECOND TRANSITIONAL MEDICAID INCOME TEST, DONE AT THE END OF MONTH TEN (10)	
STEP	**ACTION**
Step 1.	If the caretaker relative reports earnings in each of months seven (7) through nine (9) Transitional Medicaid eligibility continues. If no earnings go to Step 2.
Step 2.	If no earnings are reported for any of months seven (7) through nine (9) of Transitional Medicaid, determine if the caretaker relative has good cause for the lack of earnings. Use the criteria in Subsection 419.03. If good cause does not exist, close Transitional Medicaid. Ten (10) day advance notice is required.

( )

03. Good Cause for Lack of Earnings. Good cause for lack of earnings includes, but is not limited to: ( )

a. Family crisis. ( )

b. Court required appearance or incarceration. ( )

c. Loss of transportation where no other means of transportation is readily accessible. ( )

d. Loss of child care arrangements. ( )

e. Involuntary loss of employment. ( )

f. Illness. ( )

42~~2~~5. REASONS TO END TRANSITIONAL MEDICAID BEFORE THE END OF THE ELIGIBILITY PERIOD.
Reasons to end Transitional Medicaid are: (3-30-07)

01. Child Leaves Family Unit. The family unit no longer includes an eligible child. (3-30-07)

02. Not Residing in Idaho. The family unit no longer resides in Idaho. (3-30-07)

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. (3-30-07)

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. (3-30-07)

42~~3~~6. 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. (3-30-07)

42~~4~~7. 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. (3-30-07)

42~~5~~8. -- 499. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-0703

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 Idaho State Legislature for final approval. If approved the Legislature, the pending rule becomes final and effective on July 1, 2008, 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, 56-253, 56-255, and 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 October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, page 379.

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 to the state general fund related to this rulemaking.

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

DATED this 5th day of November, 2007.

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 NOTICE PUBLISHED WITH THE PROPOSED RULE

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0301-0703***
Eligibility for Health Care Assistance for Families and Children ***PENDING RULE***

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236, 56-237, 56-238, 56-239, 56-240, 56-242, 56-250, 56-253, 56-255, and 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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 revises the reporting requirements to state that all Medicaid participants must report any changes in their circumstances that may affect their benefits by the 10th of the month following the month in which the change occurred.

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 this rulemaking is being done to align the reporting requirements with rules for the Food Stamp program and is based on federal recommendations.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the 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 October 24, 2007.

DATED this 15th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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*~~ by the tenth of the month following the month in which the change occurred. Report of changes may be made verbally, in writing, through personal contact, telephone, fax, electronic mail, or mail. ~~*(3-30-07)*~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 56-203, 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 Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 383 through 385.

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 to the state general fund related to this rulemaking.

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

DATED this 30th day of October, 2007.

Sherri Kovach
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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0304-0701***
Rules Governing the Food Stamp Program in Idaho ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 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 rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-203, 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 17, 2007.

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 less error-prone and make the requirements for reporting changes in circumstances consistent for all food stamp households, the Department is amending the rules to make the reporting timeframe the same for all food stamp households. The Department is also amending two sections of rules to bring them into compliance with federal regulations regarding the treatment of applications for food stamp benefits.

The rule amendments confer benefits to food stamp households as follows:

1. **Standardization of the monthly reporting date on which all food stamps households must report any changes in their circumstances will make change reporting easier for food stamp households. It will also provide them with an additional month of benefits when the change being reported will end food stamp benefits for the household.**
2. **A new reference to the Code of Federal Regulations (CFR) points to the requirement that a new food stamp application must be filed if a food stamp applicant fails to attend or reschedule the eligibility interview within 30 days of submitting the application. This will make it easier for food stamp households to understand how long they can delay completing the application process (e.g., by not attending an interview) without having to file a new application.**
3. **A second new reference to the Code of Federal Regulations (CFR) points to the requirements for how to prorate the food stamp benefit amount when a food stamp applicant delays the processing of the application. The result is that food stamp households will receive benefits back to the application date if they attempt to reschedule the required eligibility interview within 30 days and provide the**

required verifications within 10 days of the interview; if they attend the interview, and fail to provide the required eligibility verifications within 10 days, but subsequently provide these verifications between days 30 and 60 after their initial application, they will receive benefits back to the first day of the month following the month of application. Currently, they only receive benefits starting the day they finally provide their verifications.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers a benefit to food stamp participants.

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

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

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking is being done to bring food stamp rules into compliance with federal regulations and increase consistency in the Food Stamp Program.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Rosie Andueza (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 Wednesday, October 24, 2007.

DATED this 22nd day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

106. DETERMINATION OF WHEN A NEW APPLICATION FOR ASSISTANCE (AFA) ~~*NOT*~~ IS REQUIRED.
~~*A new AFA is not required if the household delays processing thirty (30) days following the application and the Department denies the application, then the household takes the required action within sixty (60) days of the application date.*~~ The Department must follow the procedure outlined in 7 CFR 273.2(g) and (h) in determining when a food stamp household is required to fill out a new application for assistance (AFA). ~~*(6-1-94)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

147. CASE ACTION AFTER DELAY CAUSED BY HOUSEHOLD.
~~*The Department will send notice and deny an application if the household caused the delay by filing an incomplete application, failing to attend an interview, or not providing required verification. If the household takes required action within sixty (60) days after the application date, the Department will reopen the case without a new application.*~~ The Department must follow the procedure outlined in 7 CFR 273.2(g) and (h) in determining the appropriate action to take on food stamp benefits when the household has delayed completing the application process. ~~*(4-11-06)*~~(____)

~~***01. First Thirty Day Period****. If the household caused the delay during the first thirty (30) day period and provides proof by the thirtieth day, reopen the case and prorate benefits from the date of application.* *(4-11-06)*~~

~~***02. Second Thirty Day Period****. If the household caused the delay during the first thirty (30) day period and is eligible during the second thirty (30) day period, the Department will approve Food Stamps for the month after the application month. Food Stamps for the month after the application month must be prorated from the date the household provides requested proof. The Department will not issue food stamps for the application month.* *(4-11-06)*~~

(BREAK IN CONTINUITY OF SECTIONS)

389. REPORTING RESOURCES.
~~*Recipient h*~~Households receiving food stamps must report resource changes at each recertification. Change reporting households must also report ~~*changes within ten (10) days after receiving a new resource. A household must report*~~ when cash on hand, stocks, bonds, or money in a financial institution reaches or exceeds the resource limit. A household must report if it obtains a vehicle. ~~*(4-11-06)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

572. HOUSEHOLD COMPOSITION CHANGES FOR CHANGE REPORTING HOUSEHOLDS.
~~*Changes in household composition are required to be reported for change reporting households. Changes must be reported within ten (10) days of the date the change occurs. The*~~ Change reporting food stamp households must report changes in household composition. Any change reported is effective for the month after it is reported, allowing for timely notice. ~~*(4-11-06)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

611. TIME FRAMES FOR REPORTING CHANGES IN HOUSEHOLD CIRCUMSTANCES.
Households must report changes in circumstances as required by the household's reporting group. ~~*Except for income changes, households must report changes within ten (10) days of the date the change becomes known to the household. If changes in circumstances occur after the certification interview, but before the Notice of Decision is sent, the household must report changes within ten (10) days of the Notice of Decision date. For income changes, the following reporting timeframes are determined by the reporting group to which a household has been assigned:*~~ Households must report changes to the Department by the tenth day of the month following the month in which the change occurred. ~~*(4-6-05)*~~( )

01. Change ~~*Reporting Households*~~ After the Certification Interview. ~~*When a change in income listed under Subsection 601.01 of these rules is received by a change reporting household, the household must report the change within ten (10) days of receiving it.*~~ If changes in circumstances occur after the certification interview but before the Notice of Decision is sent, the household must report changes to the Department by the tenth day of the month following the month in which they receive the Notice of Decision. ~~*(4-6-05)*~~( )

02. Simplified Reporting Households. When the actual gross income received in a month by a simplified reporting household is greater than one hundred thirty percent (130%) of the poverty limit for the household size, the household must report this change by the tenth day of the month ~~*after*~~ following the month in which the income exceeded the limit. ~~*(4-6-05)*~~( )

03. Must Not Impose Added Reporting Requirements. The Department must not require additional household reporting not listed in these rules. (6-1-94)

04. Report Form. The Department must give households a Change Report Form at certification, at recertification, when the household reports a change, and when the household requests the form. (4-6-05)

05. Reporting Methods. Changes can be reported by telephone, personal contact, or mail. Changes can be reported by a household member or authorized representative. (6-1-94)

06. Failure to Report. If Food Stamps are overissued because a household fails to report required changes, a Claim Determination must be prepared. A person can be disqualified for failure to report a change if he commits an Intentional Program Violation. (7-1-99)

HOUSE HEALTH AND WELFARE COMMITTEE

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND, AND DISABLED (AABD)

DOCKET NO. 16-0305-0702

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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, Idaho Code, and SB1170, 2007 Legislature.

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 1, 2007, Idaho Administrative Bulletin, Vol. 07-8, pages 99 through 101.

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, contact Susie Cummins at (208) 732-1419.

DATED this 28th day of September, 2007.

Sherri Kovach
Program Supervisor
DHW - Administrative Procedures Section
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(208) 334-5564 phone
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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0305-0702***
Eligibility for Aid to the Aged, Blind & Disabled ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the 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 rulemaking procedures have been initiated. This rulemaking action is authorized pursuant to Section 56-202, Idaho Code, and SB1170, 2007 Legislature.

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

Date:	**August 13, 2007**	**August 13, 2007**
Time:	**6:30 p.m.**	**7:00 p.m.**
Place:	**Department of Health & Welfare** **Region IV Office** **1720 Westgate Dr.,** **Suite D, Room 119** **Boise, Idaho**	**State Office Building** **1118 "F" Street** **3rd Floor Conference room** **Lewiston, 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 non-technical explanation of the substance and purpose of the proposed rulemaking:

During the 2007 Legislative Session, Senate Bill 1170 was passed. This Bill updated Medicaid eligibility criteria in Sections 56-1302 and 56-1303, Idaho Code. This new language in the Idaho statutes follows the intent of Long Term Care Partnership policies as described in the Federal Deficit Reduction Act (DRA) of 2005. The changes in statute eliminate the requirement that the qualified long-term care policy must be exhausted before the individual can be eligible for an asset disregard when eligibility for Medicaid is determined. This rulemaking aligns the eligibility requirements regarding excluded resources with the changes in statute.

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 meet federal regulations time lines and confer a benefit.

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 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 conducted. The "Notice of Intent to Promulgate - Negotiated Rulemaking" was published in the Idaho Administrative Bulletin, May 2, 2007 - Vol. 07-05, page 58.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Susie Cummins at (208) 732-1419.

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 22, 2007.

DATED this 20th day of June, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

710. -- 7~~20~~19. (RESERVED).

72~~1~~0. 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 16.03.10, "Medicaid Enhanced Plan Benefits." (3-30-07)

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 72~~1~~0.04.a. through 72~~1~~0.04.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)

721. QUALIFIED LONG-TERM CARE PARTNERSHIP POLICY.
Participants who have received, or are entitled to receive, benefits under a Qualified Long-Term Care Partnership policy issued in Idaho after November 1, 2006, will have certain resources disregarded as described in Subsections 721.01 and 721.02 of these rules. ( )

01. Value of the Participant's Resources. The total dollar amount of the insurance benefits paid out for a policy holder of a Qualified Long-Term Care Partnership policy is disregarded in calculating the value of the participant's resources for long-term care Medicaid eligibility. The amount that is disregarded is determined on the effective date of an initial application approval for long-term care Medicaid benefits. ( )

02. Resource Disregard Excluded From Estate Recovery. The amount of the resources disregarded from a Qualified Long-Term Care Partnership policy under Subsection 721.01 of this rule, is deducted from the assets of the estate for Medicaid estate recovery. ( )

(BREAK IN CONTINUITY OF SECTIONS)

737. TREATMENT OF RESOURCES ~~*EXCLUDED FROM*~~ FOR ASSESSMENT.
~~*Resources excluded in determining AABD cash are excluded in determining the couple's total combined FSI resources except:*~~ The resource rules used in determining eligibility for AABD cash

and Medicaid are also used in determining the couple's total combined resources for the FSI resource assessment with the following exceptions: ~~(3-30-07)~~( )

01. Resources For Sale. Excess resources offered for sale, are not excluded from the couple's total combined resources for the FSI resource assessment. (3-30-07)

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. (3-30-07)

03. Long-Term Care Partnership Policy. Resources excluded because of a participant's qualified long-term care policy are not excluded for the FSI resource assessment. ( )

0~~3~~4. 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. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND, AND DISABLED (AABD)

DOCKET NO. 16-0305-0703

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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.

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 changes made to the proposed rules are to clarify the definition of pension funds; remove the definition of retirement funds; and change the income producing resource test from a 5% flat rate to an index. 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 October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10 pages 386 through 397.

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.

This rulemaking has no anticipated fiscal impact on the state general fund.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule, contact Susie Cummins at (208) 732-1419.

DATED this 5th day of November, 2007.

Sherri Kovach, Program Supervisor
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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0305-0703***
Eligibility for Aid to the Aged, Blind, and Disabled ***PENDING RULE***

THE FOLLOWING NOTICE 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.

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

Wednesday, October 10, 2007	**Thursday, October 11, 2007**	**Monday, October 15, 2007**
6:00 p.m. (Pacific Time)	**6:00 p.m.**	**6:00 p.m.**
Health & Welfare Reg. 1	**Health & Welfare Reg. 5**	**Health & Welfare Reg. 4**
Lower Floor Conference Room	**Conference Room A/C**	**1720 Westgate Drive**
1120 Ironwood Dr.	**601 Pole Line Road**	**Suite D, Room 119**
Coeur d'Alene, ID 83814	**Twin Falls, ID 83301**	**Boise, ID 83209**

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 Department negotiated on issues dealing with estate planning, trusts, and life estates for persons eligible for Aid to the Aged, Blind, and Disabled (AABD). Through those negotiations the following issues are being addressed:

1. **Definitions for long-term care, partnership policy, pension funds, and retirement funds;**
2. **A life estate table to determine value of the asset at the time of transfer;**
3. **Clarification to the way the community spouse resource allowance is determined when one of the couple is a long-term care participant; and**
4. **Clarification to the penalty exceptions for asset transfers.**

These rules are also being amended to change reporting requirements for changes in circumstances to align the AABD rules with other program rules. By having the same timelines, a participant enrolled in more than one assistance program would receive better customer service because of improvements in reporting accuracy and workload management.

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.

This rulemaking has no anticipated fiscal impact on the state general fund.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted. The Notice of Negotiated Rulemaking was published in the Idaho Administrative Bulletin, June 6, 2007, on page 66.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susie Cummins at (208) 732-1419.

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 24, 2007.

DATED this 22nd day of August, 2007.

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. (3-30-07)

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: (3-30-07)

a. The individual or such individual's spouse; (3-30-07)

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 (3-30-07)

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. (3-30-07)

05. 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)

06. 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)

07. Department. The Department of Health and Welfare. (7-1-99)

08. Direct Deposit. The electronic deposit of a participant's AABD cash to the participant's personal account with a financial institution. (7-1-99)

09. 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)

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)

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. 1396p(c)(1)(C). (3-30-07)

13. Medicaid. The Federally-funded program for medical care (Title XIX, Social Security Act). (5-3-03)

14. Medical Assistance Rules. Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-30-07)

15. 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)

16. **Participant**. An individual applying for or receiving assistance. (7-1-99)

17. ***Partnership Policy****. A partnership policy is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986, which meets the requirements of the long-term care insurance model regulation and long-term care insurance model act promulgated by the National Association of Insurance Commissioners (NAIC), as incorporated in 42 USC 1396p(b)(5)(A).* *(____)*

18. ***Pension Funds****. Pension funds are retirement funds held in individual retirement accounts (IRAs), as described by the Internal Revenue Code, or in work-related pension plans, including plans for self-employed individuals sometimes referred to as Keogh plans.* *(____)*

1~~7~~*9*. **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)

***~~18~~20*.** **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~~21*.** **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. (3-30-07)

2~~0~~*2*. **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. (3-30-07)

23. ***Treasury Rate****. The five (5) year security note rate listed in the "Daily Treasury Yield Curve Rate" by the U.S. Treasury on January 1 of each year. The January 1 rate is used for the entire calendar year.* *(____)*

2~~1~~*4*. **Working Day**. A calendar day when regular office hours are observed by the state of Idaho. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

605. REPORTING REQUIREMENTS.
The participant must report changes in circumstances verbally or in writing, ~~*within ten (10) calendar days from the date the change becomes known to him*~~ by the tenth of the month following the month in which the change occurred. The participant must show good cause for not reporting changes. If failure to report a change results in an overpayment, the overpayment must be recovered. ~~*(7-1-99)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

735. FEDERAL SPOUSAL IMPOVERISHMENT (FSI) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.
The FSI method must be used to compute income and resources of a married participant, who requires long-term care ~~*participant*~~ as defined in Section 005 of these rules, ~~*with*~~ and who has a community spouse. The participant must have entered long-term care on or after September 30, 1989. Terms used in the FSI method are listed in Subsections 735.01 through 735.05 of this rule.
~~*(7-1-99)*~~(____)

01. Long-Term Care Spouse. The long-term care spouse must be in a medical institution or nursing facility, or be an HCBS participant, for thirty (30) consecutive days, or appear likely to meet the thirty (30) days requirement. (7-1-99)

02. Community Spouse. The community spouse is the husband or wife of the long-term care participant. A community spouse is not in long-term care and is not an HCBS participant. (7-1-99)

03. Continuous Period of Long-Term Care. A continuous period of long-term care is a period of residence either in a medical institution with nursing facility services, or at home with HCBS. A continuous period of long-term care is also a combination of institution and personal care services likely to last at least thirty (30) consecutive days. Absence from the institution, or a lapse in HCBS eligibility, of thirty (30) consecutive days breaks continuity. The thirty (30) consecutive days of long-term care must not begin on a day the participant is hospitalized. If the participant is hospitalized after the first day of the thirty (30) consecutive days, the hospital stay does not interrupt the thirty (30) consecutive days. (7-1-99)

04. Start of Continuous Period. The start of a continuous period of long-term care is the first month of long-term care or HCBS. (7-1-99)

05. Nursing Facility Services. Nursing facility services are services at the nursing facility level or the intermediate care for the mentally retarded level provided in a medical institution. (7-1-99)

736. ASSESSMENT DATE AND COUNTING FSI RESOURCES.
The assessment date is the start date of the first continuous period of long-term care~~*, on or after September 30, 1989*~~. The Department does a one-time assessment to determine the value of the couple's community and separate resources as of the date of the first continuous period of long-term care~~*on or after September 30, 1989*~~. The resource assessment is done at the request of either spouse, after one spouse is in long-term care or ~~*begins*~~ meets the level of care for HCBS, whether or not the couple has applied for Medicaid. State laws relating to community property or the division of marital property are not applied in determining the FSI total combined resources of the couple. ~~*(7-1-99)*~~(____)

(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 CS~~A~~NS, the CSRA cannot be increased. If the community spouse has less income than the minimum CS~~A~~NS, the CSRA ~~*must*~~ may be increased as provided in Section 745 of these rules. 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. ~~*(3-30-07)*~~(____)

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 CS~~A~~NS, the CSRA ~~*must*~~ may 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 CS~~A~~NS Resources included in the transfer are presumed to produce income ~~*of five percent (5%) yearly*~~ *at the treasury rate*, 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*~~ *treasury rate* requirement. Actual income produced by the resources transferred to the community spouse is used to compute the CSA. A higher CSA can be requested under Section 727 of these rules. If the transferred resources produce more than ~~*five percent (5%) yearly income*~~ *the treasury rate*, 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.
~~*(3-30-07)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

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 the requirements in Subsections 799.01 through 799.07 of this rule. (3-30-07)

01. Non-Financial Requirements. An individual must: (3-30-07)

a. Be at least sixteen (16) but less than sixty-five (65) years of age; (3-30-07)

b. Meet the Medicaid residency requirement as described in Section 100 of these rules; (3-30-07)

c. Meet the citizenship requirements as described in Sections 105 and 106 of these rules; (3-30-07)

d. Meet the SSN requirements as described in Section 104 of these rules; and

(3-30-07)

e. Meet the child support cooperation requirements as described in Sections 703 through 706 of these rules. (3-30-07)

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. (3-30-07)

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. (3-30-07)

04. Resources. 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: (3-30-07)

a. Any resources excluded under Sections 200 through 299 of these rules; (3-30-07)

b. A second vehicle as described in Sections 222 of these rules; (3-30-07)

c. Life insurance policies; (3-30-07)

d. Retirement accounts; and (3-30-07)

e. Exempt trusts as described in Section 872 of these rules. (3-30-07)

05. Countable Income. Countable income is calculated using exclusions and disregards as described in Sections 300 through ~~499~~ 547 of these rules. ~~(3-30-07)~~( )

a. An individual's countable income cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of one (1). (3-30-07)

b. A couple's countable income cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of two (2). (3-30-07)

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. (3-30-07)

06. Cost-Sharing. A participant in the Medicaid for Workers with Disabilities coverage group may be required to cost-share. If a participant is required to cost-share for Medicaid, the costs are determined under the provisions in IDAPA 16.03.18, "Medicaid Cost-Sharing." (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

834. PERIOD OF RESTRICTED COVERAGE FOR ASSET TRANSFERS.
The period of restricted coverage is the number of months computed by dividing the net uncompensated value of the transferred asset by the statewide average cost of nursing facility services to private patients. 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. ~~*(3-30-07)*~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

837. LIFE ESTATE AS ASSET TRANSFER.

01. Transfer of a Remainder Interest. When a life estate in real property is retained by an individual, and a remainder interest in the property is transferred during the look-back period for less than the fair market value 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. 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**	.009~~2~~92
4	.01019	**5**	.01062	**6**	.01116	**7**	.01178
8	.01252	**9**	.01337	**10**	.01435	**11**	.01547
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

TABLE 837.01 - ~~LIFE ESTATE~~ REMAINDER TABLE							
Age	**~~Life Estate~~ Remainder**	**Age**	**~~Life Estate~~ Remainder**	**Age**	**~~Life Estate~~ Remainder**	**Age**	**~~Life Estate~~ Remainder**
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				

~~(3-30-07)~~(_____)

02. **Transfer of a Life Estate**. When a life estate in real property is transferred by an individual during the look-back period for less than fair market value, the value of the life estate is subject to the asset transfer penalty as described in Sections 831 and 835 of these rules. To compute the value of the life estate, multiply the fair market value of the real property at the time of transfer by the life estate factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.02 - LIFE ESTATE TABLE							
Age	**Life Estate**	**Age**	**Life Estate**	**Age**	**Life Estate**	**Age**	**Life Estate**
0	.97188	**1**	.98988	**2**	.99017	**3**	.99008
4	.98981	**5**	.98938	**6**	.98884	**7**	.98822
8	.98748	**9**	.98663	**10**	.98565	**11**	.98453
12	.98359	**13**	.98198	**14**	.98066	**15**	.97937
16	.97815	**17**	.97700	**18**	.97590	**19**	.97480
20	.97365	**21**	.97425	**22**	.97120	**23**	.96986
24	.96841	**25**	.96678	**26**	.96495	**27**	.96290
28	.96062	**29**	.95813	**30**	.95543	**31**	.95254

TABLE 837.02 - LIFE ESTATE TABLE							
Age	**Life Estate**	**Age**	**Life Estate**	**Age**	**Life Estate**	**Age**	**Life Estate**
32	.94942	**33**	.94608	**34**	.94250	**35**	.93868
36	.93460	**37**	.93026	**38**	.92567	**39**	.92083
40	.91571	**41**	.91030	**42**	.90457	**43**	.89855
44	.89221	**45**	.88558	**46**	.87863	**47**	.87137
48	.86374	**49**	.85578	**50**	.83743	**51**	.83674
52	.82969	**53**	.82028	**54**	.81054	**55**	.80046
56	.77006	**57**	.77391	**58**	.76822	**59**	.75675
60	.74491	**61**	.73267	**62**	.72002	**63**	.70696
64	.69352	**65**	.67970	**66**	.66551	**67**	.65098
68	.63610	**69**	.62086	**70**	.60522	**71**	.58914
72	.57261	**73**	.55571	**74**	.53862	**75**	.52149
76	.50441	**77**	.48742	**78**	.47049	**79**	.45357
80	.43659	**81**	.41967	**82**	.40295	**83**	.38642
84	.36998	**85**	.35359	**86**	.33764	**87**	.32262
88	.30859	**89**	.29526	**90**	.28221	**91**	.26955
92	.25771	**93**	.24692	**94**	.23728	**95**	.22887
96	.22181	**97**	.21550	**98**	.21000	**99**	.20486
100	.19975	**101**	.19532	**102**	.19054	**103**	.18437
104	.17856	**105**	.16962	**106**	.15488	**107**	.13409
108	.10068	**109**	.04545				

(____)

838. 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,*~~ *Proof is met if* the participant ~~*must*~~ shows 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*~~ *meets the requirements* described in Subsections 838.02 through 838.0~~4~~*5* of ~~*these*~~ *this* rules~~*, unless the annuity is permitted under Section 838.05*~~. ~~*(3-30-07)*~~*(____)*

01. Revocable Annuity. *A revocable annuity is an annuity that can be assigned.* The surrender amount of a revocable annuity is a countable resource. ~~*(3-30-07)*~~*(____)*

02. Irrevocable Annuity. ~~*An irrevocable annuity is an 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, *non-assignable* annuity is treated as an asset transfer, unless the requirements of Subsections 838.02.a, 838.02.b., 838.03 and 838.04 of ~~these~~ *this* rule~~s~~ are met. ~~(3-30-07)~~*( )*

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 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 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

(3-30-07)

b. Annual Interest ~~***and Insurer Rating***~~ **Test**. ~~*The*~~ *Any* annuity ~~*must*~~ *is presumed to*

produce ~~*annual*~~ interest~~ *of at least five percent (5%)*~~, *at minimum, that is equal to the treasury rate*. ~~*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. To rebut the five percent (5%) interest test, 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 insurer must be rated excellent or superior by an insurance rating firm.*~~
~~*(3-30-07)*~~*(____)*

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: (3-30-07)

a. The remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the ~~*annuitant*~~ institutionalized individual under this title; or
~~*(3-30-07)*~~*(____)*

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. (3-30-07)

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. (3-30-07)

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. (3-30-07)

(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*~~ this rule~~*s*~~. ~~*(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*~~ received payment from Medicaid for home and community based services ~~*as a paid Medicaid provider*~~ provided to the participant. ~~*(3-30-07)*~~( )

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. 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.d. of ~~*these*~~ this rule~~*s*~~ apply. ~~*(3-30-07)*~~( )

a. The participant proves he is not able to pay for his nursing facility services or his wavier services by any means. (3-30-07)

b. The participant proves that he has made reasonable efforts, consistent with his physical and financial ability, to recover the transferred asset. 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. (3-30-07)

c. The participant proves he did not knowingly transfer the asset. (3-30-07)

d. 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. (3-30-07)

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*~~ this rule~~*s*~~. ~~*(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 to qualify for assistance or to avoid recovery. ~~*(3-30-07)*~~( )

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*~~ this rule~~*s*~~. ~~*(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. (3-30-07)

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)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND, AND DISABLED (AABD)

DOCKET NO. 16-0305-0704

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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, 56-203, 56-207 through 209a, and 56-253 through 255, Idaho Code, and the federal Tax Relief and Health Care Act of 2006 (TRHCA), and Deficit Reduction Act of 2005 (DRA).

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 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 398 through 406.

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 the income trust issue is $281,043. The federal match is 70/30, and the total cost to the state general fund is $84,300.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule, contact Susie Cummins at (208) 732-1419.

DATED this 31st day of October, 2007.

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@dhw.idaho.gov e-mail

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0305-0704***
Eligibility for Aid to the Aged, Blind, and Disabled ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rules are July 1, 2007, July 13, 2007 and October 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, 56-203, 56-207 through 209a, and 56-253 through 255, Idaho Code, and the federal Tax Relief and Health Care Act of 2006 (TRHCA), and Deficit Reduction Act of 2005 (DRA).

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

Wednesday, October 10, 2007	**Thursday, October 11, 2007**	**Monday, October 15, 2007**
6:00 p.m. (Pacific Time)	**6:00 p.m.**	**6:00 p.m.**
Health & Welfare Region 1	**Health & Welfare Region 5**	**Health & Welfare Region 4**
Lower Floor Conference Room	**Conference Room A/C**	**1720 Westgate Drive**
1120 Ironwood Dr.	**601 Pole Line Road**	**Suite D, Room 119**
Coeur d'Alene, ID	**Twin Falls, ID**	**Boise, ID**

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

DESCRIPTIVE SUMMARY: The following is 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:

1. **Section 104 - Social Security Number (SSN) Requirement. This rule is being amended to be align with the federal terminology for a deemed newborn child.**

2. **Section 105 - U.S. Citizenship and Identity Documentation. Final federal regulations regarding Medicaid citizenship and identity requirements were published in the Federal Register on July 13, 2007. The citizenship and identity documentation rules are being amended to align with these regulations, which expand the types of documentation that can be used to establish citizenship and identity and exempts additional groups from the requirements.**

3. **Section 618 - Continued Benefits Pending a Hearing Decision. When a participant disagrees with an eligibility decision, they have a right to request continued benefits pending the fair hearing. Per federal regulations, the participant has until the effective date of the action to request continued benefits. This rule change aligns Idaho Medicaid rules with federal regulations.**

4. **Section 872 - Exempt Trusts. An individual who would otherwise be over the income limit for long-term care eligibility is allowed to place his income in trust and then used to meet the cost of care in the nursing home. The federal policy allows the person to become eligible in the same month that money is received and placed in the trust. Currently, Idaho requires the individual to change ownership of his income to the trust before it is not counted toward eligibility. The time it takes to make this change causes a delay and a hardship on applicants who do not have enough income to pay the private pay rate for their long-term care, but are over the Medicaid income limit. This rule change allows an individual to become eligible if the income is placed in trust the same month it is received.**

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 changes are being made to align current rules with federal regulations and confer a benefit to individuals applying for Medicaid.

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

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

The fiscal impact for the income trust issue is $281,043. The federal match is 70/30, and the total cost to the state general fund is $84,300.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted. The Notice of Negotiated Rulemaking was published in the Idaho Administrative Bulletin, June 6, 2007 on page 66 under Docket No. 16-0305-0703 for the issue of income trusts. Negotiated rulemaking was not conducted on the issues of citizenship, identity, or continued benefits.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Susie Cummins at (208) 732-1419.

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 24, 2007.

DATED this 20th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

104. 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 deemed eligible as described in Section 800 of these rules. ~~*(3-20-04)*~~(____)

105. U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.
To be eligible for Medicaid, an individual must provide documentation of U.S. citizenship and identity unless he has otherwise met the requirements under Subsection 105.0~~8~~9 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. ~~*(3-30-07)*~~(____)

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: (3-30-07)

a. A U.S. passport; (3-30-07)

b. A Certificate of Naturalization, DHS Forms N-550 or N-570; or (3-30-07)

c. A Certificate of U.S. Citizenship, DHS Forms N-560 or N-561. (3-30-07)

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 105.01 of this rule 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~~ through 105.0~~6~~7 of this rule to establish both citizenship and identity. ~~(3-30-07)~~( )

a. A U.S. birth certificate that shows the individual was born in one (1) of the following: (3-30-07)

i. United States fifty (50) states; (3-30-07)

ii. District of Columbia; (3-30-07)

iii. Puerto Rico, on or after January 13, 1941; (3-30-07)

iv. Guam, on or after April 10, 1899; (3-30-07)

v. U.S. Virgin Islands, on or after January 17, 1917, (3-30-07)

vi. America Samoa; (3-30-07)

vii. Swain's Island; or (3-30-07)

viii. Northern Mariana Islands, after November 4, 1986; (3-30-07)

b. A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545; (3-30-07)

c. A report of birth abroad of a U.S. Citizen, Form FS-240; (3-30-07)

d. A U.S. Citizen I.D. card, DHS Form I-197; (3-30-07)

e. A Northern Mariana Identification Card, Form I-873; (3-30-07)

f. An American Indian Card issued by the Department of Homeland Security with the classification code "KIC," Form I-873; (3-30-07)

g. A final adoption decree showing the child's name and U.S. place of birth; (3-30-07)

h. Evidence of U.S. Civil Service employment before June 1, 1976; ~~or~~

~~(3-30-07)~~(____)

i. An official U.S. Military record showing a U.S. place of birth~~.~~; ~~(3-30-07)~~(____)

j. A certification of birth abroad, FS-545; (____)

k. A verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database; or (____)

l. Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000. (____)

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~~ through 105.0~~6~~7 of this rule to establish both citizenship and identity. ~~(3-30-07)~~(____)

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~~ ~~(3-30-07)~~(____)

b. A ~~L~~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~~.~~; ~~(3-30-07)~~(____)

c. A religious record recorded in the U.S. within three (3) months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization; or (____)

d. An early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the names and places of the birth of the child's parents. (____)

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~~ through 105.0~~6~~7 of this rule to establish both citizenship and identity. ~~(3-30-07)~~(____)

a. Federal or state census record that shows the individual has U.S. citizenship or a U.S. place of birth; (3-30-07)

b. One (1) of the following documents that shows a U.S. place of birth and for a participant who is sixteen (16) years of age or older was created at least five (5) years before the application for Medicaid. For a child under sixteen (16) years or age, the document must have

been created near the time of birth; ~~*(3-30-07)*~~(____)

i. Seneca Indian tribal census record; (3-30-07)

ii. Bureau of Indian Affairs tribal census records of the Navajo Indians; (3-30-07)

iii. U.S. State vital Statistics official notification of birth registration; (3-30-07)

iv. A~~*n amended*~~ delayed U.S. public birth record that ~~*is amended*~~ was recorded more than five (5) years after the person's birth; ~~*(3-30-07)*~~(____)

v. Statement signed by the physician or midwife who was in attendance at the time of birth; (3-30-07)

vi. Medical (clinic, doctor, or hospital) record; (3-30-07)

vii. Institutional admission papers from a nursing facility, skilled care facility or other institution; ~~*or*~~ ~~*(3-30-07)*~~(____)

viii. Bureau of Indian Affairs (BIA) roll of Alaska Natives; or (____)

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 for proof of U.S. citizenship or naturalization if no other documentation is available and complies with the following: ~~*(3-30-07)*~~(____)

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; (3-30-07)

ii. One (1) of the persons making a declaration cannot be related to the individual claiming U.S. citizenship; (3-30-07)

~~*iii. Neither of the two (2) persons making the declaration can be an applicant or recipient of Medicaid;*~~ ~~*(3-30-07)*~~

i~~v~~ii. The persons making the declaration must provide proof of their own U.S. citizenship and identity; and (3-30-07)

~~*v. The persons making the declaration must provide an explanation as to why documentation for the individual does not exist or cannot be obtained.*~~ ~~*(3-30-07)*~~

~~v~~iv. 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. (3-30-07)

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 Subsection 105.0~~1~~2 through 105.04 of this

rule to establish both citizenship and identity. ~~(3-30-07)~~(____)

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; (3-30-07)

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 105.05.a of this rule; (3-30-07)

c. School identification card with a photograph of the individual; (3-30-07)

d. U.S. Military card or draft record; (3-30-07)

e. Military dependent's identification card; (3-30-07)

f. U. S. Coast guard Merchant Mariner card; (3-30-07)

g. Certificate of Degree of Indian blood; ~~or~~ ~~(3-30-07)~~(____)

h. Native American Indian or Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual~~.~~; ~~(3-30-07)~~(____)

i. A cross-match with a federal or state governmental, public assistance, law enforcement, or corrections agency's data system; or (____)

j. A declaration signed under the penalty of perjury by the facility director or administrator of a residential care facility where a disabled participant resides may be accepted as proof of identity when the individual does not have or cannot get any document in Subsections 105.05.a. through 105.05.i. of this rule. (____)

06. Additional Documents Accepted for Proof of Identity. If the participant provides citizenship documentation as described in Subsections 105.02 or 105.03 of this rule, three (3) or more corroborating documents may be used to prove identity. (____)

0~~6~~7. Identity Rules for Children. The following documentation of identity for children under sixteen (16) may be used: (3-30-07)

a. School records may be used to establish identity. Such records also include nursery or daycare records. (3-30-07)

b. Clinic, doctor, or hospital records. (____)

~~b~~c. 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: (3-30-07)

i. It states the date and place of the child's birth; and (3-30-07)

ii. It is signed by a parent or guardian. (3-30-07)

d. A declaration can be used for a child up to the age of eighteen (18) when documents listed in Subsection 105.05.a. through 105.05.c. of this rule are not available. ( )

~~c~~**e.** A declaration cannot be used for identity if a declaration for citizenship documentation was provided for the child. (3-30-07)

0~~7~~8. Eligibility for Applicants and Medicaid Participants Who Do Not Provide Citizenship and Identity Documentation. (3-30-07)

a. Eligibility will be denied to any applicant who does not provide proof of citizenship and identity documentation; (3-30-07)

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: (3-30-07)

i. Does not meet other eligibility criteria required in this chapter of rules; or (3-30-07)

ii. Refuses to obtain the documentation. (3-30-07)

0~~8~~9. 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 105.0~~7~~8 of this rule is provided: ~~(3-30-07)~~( )

a. Supplemental Security Income (SSI) recipients; ~~and~~ ~~(3-30-07)~~( )

b. Individuals determined by the SSA to be entitled to or are receiving Medicare~~.~~; ~~(3-30-07)~~( )

c. Social Security Disability Income (SSDI) recipients; and ( )

d. Adoptive or foster care children receiving assistance under Title IV-B or Title IV-E of the Social Security Act. ( )

~~***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.*~~ ~~(3-30-07)~~

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. (3-30-07)

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. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

618. CONTINUED BENEFITS PENDING A HEARING DECISION.
The participant may continue to receive ~~*assistance*~~ benefits upon request, pending the hearing decision. The Department must receive the participant's request for continued benefits ~~*within ten (10) days of mailing*~~ before the effective date of the Department's action stated in the notice of decision. ~~*(3-15-02)*~~(____)

01. Amount of Assistance. The Department will continue the participant's assistance at the current month's level while the hearing decision is pending, unless another change affecting assistance occurs. (3-15-02)

02. Continued Eligibility. The participant must continue to meet all eligibility requirements not related to the hearing issue. (3-15-02)

03. Overpayment. When the hearing decision is in the Department's favor, the participant must repay assistance received while the hearing decision was pending. (3-15-02)

(BREAK IN CONTINUITY OF SECTIONS)

872. EXEMPT TRUSTS.
A trust, created or funded on or after August 11, 1993, is exempt from trust treatment and not subject to the asset transfer penalty if it meets a condition in Subsections 872.01 through 872.03 of ~~*these*~~ this rule~~s~~. ~~*(3-20-04)*~~(____)

01. Trust for Disabled Person. To be exempt, a trust for a disabled person must meet all the conditions in Subsections 872.01.a. through 872.01.f. of ~~*these*~~ this rule~~s~~. ~~*(3-20-04)*~~(____)

a. The trust contains the assets of a person under age sixty-five (65). (7-1-99)

b. The person is blind or totally disabled under the Social Security and SSI rules in 20 CFR Part 416. (7-1-99)

c. The trust is established for the person's benefit by his parent, grandparent, legal guardian or a court. (7-1-99)

d. The trust is irrevocable. (7-1-99)

e. The trust is exempt until the person reaches age sixty-five (65). After the person reaches age sixty-five (65), additions or augmentations are not exempt from trust treatment. (3-20-04)

f. Upon the person's death, the amount not distributed by the trust must first be paid to the state of Idaho, up to the amount Medicaid has paid on the person's behalf. (3-20-04)

02. Income Trust. To be exempt, an income trust must meet all the conditions in Subsections 872.02.a. through 872.02.~~f~~e. of ~~*these*~~ this rule~~s~~. ~~*(3-20-04)*~~(____)

a. The trust is established for the sole benefit of a person who would be eligible for Medicaid in long-term care, or eligible for HCBS except for excess income. (3-20-04)

b. ~~*All the money in the trust comes from the person's pensions, Social Security and other income, including income earned by the trust. Money paid into the trust is not income for Medicaid eligibility the month received.*~~ Any income, placed directly into an income trust in the same calendar month in which received by the recipient, is not considered income to the individual for determining long-term care Medicaid eligibility. Money paid into the trust is income for patient liability or client participation. ~~*(7-1-99)*~~(____)

c. The trust is irrevocable. The trust document may include a clause allowing the trust to be revoked if the participant leaves the nursing facility or HCBS for a reason other than death, and is no longer eligible for Medicaid because of excess income, if Medicaid is reimbursed up to the amount Medicaid has paid on the person's behalf. (3-20-04)

d. ~~*The trust only provides payments for patient liability or client participation, unless the payment meets the undue hardship penalty exception.*~~ Income transferred to the trust must be used to pay patient liability or client participation. If income is not used to pay allowable expenses, it is subject to the asset transfer penalty, unless one (1) of the following exceptions in Subsections 872.02.d.i. through 872.02.d.iii. of this rule applies. ~~*(7-1-99)*~~(____)

i. Benefit of the spouse in Subsection 841.05 of these rules; (____)

ii. Transfer from the spouse in Subsection 841.06 of these rules; or (____)

iii. Undue hardship in Subsection 841.11 of these rules. (____)

~~**e.**~~ ~~*Income transferred to the trust and not used to compute patient liability or client participation, is subject to the asset transfer penalty, unless the payment meets the undue hardship penalty exception.*~~ ~~*(7-1-99)*~~

~~**f.**~~**e.** Upon the person's death, the amount not distributed by the trust must first be paid to the state of Idaho, up to the amount Medicaid has paid on the person's behalf. (3-20-04)

03. Trust Managed by Non-Profit Association for Disabled Person. To be exempt, a trust managed by non-profit association for a disabled person must meet all the conditions in Subsections 872.03.a. through 872.03.e. of ~~*these*~~ this rule~~s~~. ~~*(3-20-04)*~~(____)

a. The trust is established and managed by a nonprofit association. The nonprofit association must not be the participant, his parent or his grandparent. (7-1-99)

b. The trust contains the assets of a disabled person. The person must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. (7-1-99)

c. Accounts in the trust are established only for the benefit of disabled persons. An account can be established by the disabled person, his parent, grandparent, legal guardian, or a court. A separate account must be maintained for each beneficiary of the trust. For purposes of investment and management, the trust may pool the funds in the accounts. (3-20-04)

d. The trust is irrevocable. (7-1-99)

e. Upon the person's death, the amount not distributed by the trust must first be paid to the state of Idaho, up to the amount Medicaid has paid on the person's behalf. (3-20-04)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.06 - RULES GOVERNING REFUGEE MEDICAL ASSISTANCE

DOCKET NO. 16-0306-0701 (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 2008 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 56-203, Idaho Code; also 45 CFR Parts 400 and 401, and 8 USC 1521.

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 Book 1 of the Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, page 407.

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 to the state general fund related to this rulemaking.

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

DATED this 30th day of October, 2007.

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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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0306-0701***
Rules Governing Refugee Medical Assistance ***PENDING RULE***

THE FOLLOWING NOTICE 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 and 56-203, 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 17, 2007.

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 is being repealed in its entirety. The text of the rewritten chapter IDAPA 16.03.06, "Refugee Medical Assistance," appears under Docket No. 16-0306-0702 that is being published simultaneously with this docket.

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 is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking and the related chapter rewrite are the result of ongoing discussions between the Department and the Mountain States Group (refugee center), the primary advocacy agency for refugees in Idaho.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the 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, October 24, 2007.

DATED this 22nd day of August, 2007.

IDAPA 16.03.06 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.06 - REFUGEE MEDICAL ASSISTANCE

DOCKET NO. 16-0306-0702 (CHAPTER REWRITE)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 56-203, Idaho Code; also 45 CFR Parts 400 and 401, and 8 USC 1521.

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 Book 1 of the Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 408 through 416.

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:

This rule change requires updates to the Department's automated eligibility determination system (EPICS) estimated to cost $1,900. However, no net increase in operational costs is anticipated as a result of this rule change.

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

DATED this 30th day of October, 2007.

Sherri Kovach
Program Supervisor
DHW - Administrative Procedures Section
450 West State Street - 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0306-0702***
Refugee Medical Assistance ***PENDING RULE***

THE FOLLOWING NOTICE 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 and 56-203, Idaho Code; also 45 CFR Parts 400 and 401, and 8 USC 1521.

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 17, 2007.

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 is being rewritten to increase the accountability, consistency, accuracy, and efficiency of these administrative rules. As part of the rewrite, the rules are being reorganized to make it easier for the public and Department staff to locate information within the rules. In addition, the sections required by the Office of Administrative Rules (OAR) are either being updated to meet the Department's plain language standard or added because they are missing. Addition of the missing "required sections" is needed to bring the rule chapter into compliance with the OAR standards. Obsolete or otherwise incorrect citations are also being updated.

One major change in content will also being included in the rewrite. With the support of refugee advocates, the Department proposes to change the income limits for this chapter from the Aid to Families with Dependent Children (AFDC) payment standard of 1993 to 150% of the Federal Poverty Guidelines (FPG) based on the size of the refugee family. This proposed increase in the income limits will allow more refugees to be eligible for the 100% federally-funded Refugee Medical Assistance Program*. This change may enable refugees and their families to address their health issues sooner rather than later. As a result, they may be better able to maintain employment, obtain access to health insurance, and be less likely to go on Medicaid after the 8 months of Refugee Medical Assistance is exhausted.

***This is not part of the Medicaid program and does not involve Medicaid funding.**

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.

This rule change requires updates to the Department's automated eligibility determination system (EPICS) estimated to cost $1,900. However, no net increase in

operational costs is anticipated as a result of this rule change.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rulemaking is the result of ongoing discussions between the Department and the Mountain States Group (refugee center), the primary advocacy agency for refugees in Idaho.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the 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, October 24, 2007.

DATED this 24th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16
TITLE 03
CHAPTER 06

16.03.06 - REFUGEE MEDICAL ASSISTANCE

000. LEGAL AUTHORITY.
This program is authorized by 45 CFR Parts 400 and 401, by Section 412E, Title IV, Pub. L. 96-212 also known as the Refugee Act of 1980, 94 Stat. 114 (8 USC 1521) and Action Transmittal ORR-AT-80-6, and by provisions of Sections 56-202 and 56-203, Idaho Code, which authorize the Department of Health and Welfare to assist needy people of the State with medical assistance and to enter into contracts with the federal government to provide assistance. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.06, “Refugee Medical Assistance.” ( )

02. Scope. This chapter of rules governs the administration of the Refugee Medical Assistance Program in the state of Idaho. ( )

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

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

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

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE -- 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. ( )

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

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

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

05. Internet Website Address. The website address is: 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. ( )

007. -- 009. (RESERVED).

010. DEFINITION OF TERMS AND ABBREVIATIONS.
For the purposes of these rules, the following terms and abbreviations are used as defined below: ( )

01. AFDC. Aid to Families with Dependent Children. AFDC is the family assistance program in effect on June 30, 1997. It was replaced by Temporary Assistance for Families in Idaho (TAFI). ( )

02. Caretaker. A person related by blood or marriage who holds legal responsibility for the care and support of a minor child or otherwise dependent individual and who is needed in the home to care for such dependent. ( )

03. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. ( )

04. Eligible Amerasian. A citizen of Vietnam born between January 1, 1962, and January 1, 1976, who has one (1) American parent. ( )

05. Entrant. A person from Cuba or Haiti who has been granted special immigration status by USCIS. ( )

06. Federal Poverty Guidelines (FPG). The federal poverty guidelines issued annually by the Department of Health and Human Services (HHS). ( )

07. HHS. United States Department of Health and Human Services. ( )

08. INA. Immigration and Nationality Act, 8 USC Sections 1101-1537. ( )

09. IRSP. Idaho Refugee Service Program. ( )

10. I-94. A white three by five (3x5) inch alien identification card issued to refugees prior to their release to a sponsor. This card gives the refugee's name, United States address, and other identifying data. The refugee status will be printed in the lower right hand corner. If a refugee does not have this card, he should be referred to USCIS to obtain one. The dependent of a repatriated United States citizen may also have an I-94 card. ( )

11. Medical Assistance Program. Services funded by Titles XIX or XXI of the federal Social Security Act, as amended. ( )

12. Refugee. An alien who: ( )

a. Because of persecution or fear of persecution on account of race, religion, or political opinion fled from his homeland; and ( )

b. Cannot return there because of fear of persecution on account of race, religion or political opinion. ( )

13. State Children's Health Insurance Program (SCHIP). SCHIP is Title XXI of the Social Security Act. It is a federal and state partnership similar to Medicaid, that expands health insurance to targeted, low- income children. ( )

14. TAFI. Temporary Assistance for Families in Idaho. TAFI is Idaho's family assistance program whose purpose is to provide temporary cash assistance for Idaho families who meet the eligibility requirements under IDAPA 16.03.08, "Rules Governing the Temporary Assistance for Families in Idaho (TAFI)" program. TAFI replaced the Aid to Families With Dependent Children (AFDC) program. ( )

15. USCIS. United States Citizenship and Immigration Services, formerly known as Immigration and Naturalization Services (INS). ( )

011. -- 099. (RESERVED).

100. IDENTIFICATION OF REFUGEES.

01. Refugee Immigration Status. A person has refugee status for purposes of assistance under the Refugee Medical Assistance Program if he is one (1) of the following:( )

a. A person from Cambodia, Laos, or Vietnam who has a Form I-94 indicating that the person has been paroled under Section 212(d)(5) of the Immigration and Nationality Act (INA). The I-94 must clearly indicate that the person has been paroled as a refugee or asylee. ( )

b. A person from Cuba who is present in the United States, and who has an I-94 indicating that the person has been paroled under Section 212(d)(5) of the INA. The I-94 must clearly indicate that the person has been paroled as a refugee or asylee. ( )

c. A person from any country who has Form I-94 indicating that the person has been: ( )

i. Paroled under Section 212(d)(5) of the INA as a refugee or asylee; or ( )

ii. Admitted as a conditional entrant under Section 203(a)(7) of the INA; or ( )

iii. Admitted as a refugee under Section 207 of INA; or ( )

iv. Granted asylum under Section 208 of INA; or ( )

d. A person who entered the United States and has Form I-151 or I-551 showing that his status has been subsequently adjusted from one (1) of the statuses in Subsection 100.02.c. of this rule to that of permanent resident alien, provided he can document his previous status. ( )

e. A child born in the United States to eligible refugee parent(s) with whom he lives. ( )

f. An Amerasian together with close family members who entered the United States beginning March 20, 1988, in immigrant status through the Orderly Departure Program. Close family members who are eligible refugees under this provision are limited to: ( )

i. The Amerasian's spouse and child(ren); ( )

ii. The mother of an unmarried Amerasian and such mother's spouse and child(ren); and ( )

iii. A person who has acted as the parent of an unmarried Amerasian and that person's

spouse and child(ren). ( )

02. Other Factors in Determining Eligibility for the Refugee Medical Assistance Program. ( )

a. An applicant who has applied for, but has not been granted asylum, is not eligible. ( )

b. A person who entered the United States as a resident alien is not eligible. ( )

c. A Form I-94 which shows a person has been paroled into the United States under Section 212(d)(5) of the INA must clearly indicate that the person has been paroled as a "Refugee" or "Asylee" if such form was issued: ( )

i. To a person from Cambodia, Laos, or Vietnam before October 1, 1997, in accordance with P.L. 106-429, Section 101(a), as amended by P.L. 108-447; or ( )

ii. To a person from Cuba; or ( )

iii. To a person from any other country at any time. ( )

d. A person whose status is Cuban/Haitian Entrant must have his eligibility for benefits under the Refugee Medical Assistance Program determined under Sections 125 and 200 of these rules. ( )

e. An Amerasian or close family member admitted as an immigrant but eligible for Refugee Medical Assistance as though he were a refugee must have either of the following documents verifying his status: ( )

i. A temporary identification document, Form I-94 stamped "Processed for I-551. Temporary evidence of lawful admission for permanent residence. Valid until (expiration date). Employment authorized." The back of Form I-94 contains the stamped word "Admitted" and is coded AM1, AM2, or AM3; or ( )

ii. A permanent identification document, Form I-551 coded AM6, AM7, or AM8. ( )

101. -- 124. (RESERVED).

125. IDENTIFICATION OF ENTRANTS.
Identification of Cuban or Haitian entrants or other entrants, and determination of their eligibility for Refugee Medical Assistance must be conducted in accordance with 45 CFR 401. ( )

126. -- 134. (RESERVED).

135. PRECEDENCE OF CATEGORICAL ASSISTANCE PROGRAMS.

01. New Applicants. An applicant for medical assistance must first have his eligibility

determined for Medicaid or SCHIP. To be eligible for Medicaid or SCHIP, the refugee must meet all the eligibility criteria for the applicable category of assistance. If the applicant is determined ineligible for Medicaid or SCHIP, then the Department will determine his eligibility for the Refugee Medical Assistance Program. ( )

02. Transfer of Cases. At the end of the eight (8) month time limit for Refugee Medical Assistance, a refugee who is determined Medicaid-eligible in accordance with IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children" or IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," will be transitioned to Medicaid without the need to submit an additional application. ( )

136. -- 149. (RESERVED).

150. REFUGEE MEDICAL ASSISTANCE PROGRAM.

01. Time Limitation. Medical assistance under the Refugee Medical Assistance Program will be limited to eight (8) consecutive months beginning with the month the refugee enters the United States. The eligibility period for a child born in the United States to parents receiving Refugee Medical Assistance expires when both of his parents with whom he is living are no longer eligible. ( )

02. Medical Only. A refugee is not required to apply for or receive Cash Assistance as a condition of eligibility for Refugee Medical Assistance. Denial or closure of Refugee Cash Assistance is not a reason to deny or close Refugee Medical Assistance. ( )

03. Refugee Cash Assistance Excluded. Refugee Cash Assistance is excluded from income and resources when determining eligibility for Refugee Medical Assistance. ( )

04. Automatic Eligibility. Refugees whose countable income does not exceed one hundred fifty percent (150%) of the Federal Poverty Guidelines are automatically eligible for Refugee Medical Assistance. ( )

05. Refugee Medical Assistance with "Spend Down." An applicant for Refugee Medical Assistance whose countable income exceeds one hundred fifty percent (150%) FPG for his family size may become eligible for Refugee Medical Assistance under certain conditions. A special provision, for refugees only, will allow those refugees whose income exceeds one hundred fifty percent (150%) FPG for his family size to subtract his medical costs from his income and thus "spend down" to the FPG limit for his family size. This "spend down" will be determined on a quarterly basis; the quarter begins with the month of application. The amount by which the refugee's income exceeds one hundred fifty percent (150%) FPG for his family size on a monthly basis is determined by: ( )

a. Using the best estimate of income to be received during the quarter; and ( )

b. Multiplying the monthly excess by three (3) to determine the quarterly "spend down." ( )

06. Counting Income and Resources for Refugee Medical Assistance with a

"Spend Down." ( )

a. Income and resources are counted or excluded in accordance with IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." The sole exception is that Refugee Cash Assistance is excluded from income and resources when determining eligibility for Refugee Medical Assistance. ( )

b. The Federal Poverty Guideline applicable for the size of the family determines the amount to which an individual or family must "spend down" to be eligible for Refugee Medical Assistance. ( )

c. Total countable resources for the family must not exceed one thousand dollars ($1,000). ( )

d. Financial resources that are not available to the refugee, including resources remaining in his homeland, can not be considered in determining eligibility for Refugee Medical Assistance. ( )

e. The income and resources of sponsors, and the in-kind services and shelter provided to refugees by their sponsors, will not be considered in determining eligibility for Refugee Medical Assistance. A shelter allowance must not be given for any in-kind shelter provided. ( )

07. Financially Responsible Relatives. ( )

a. The Department must consider the income and resources of nonrefugee spouses or parents as available to the refugee whether or not they are actually contributed, if they live in the same household. ( )

b. If the nonrefugee spouse or parent does not live with the individual, the Department must consider income and resources that are actually contributed by the spouse or parent as available to the refugee. ( )

08. Deduction of Incurred Medical Expenses. If countable income exceeds one hundred fifty percent (150%) of the Federal Poverty Guidelines for the family size, the Department must deduct from income, in the following order, incurred medical expenses that are not subject to payment by a third party: ( )

a. Medicare premiums, other health insurance premiums, deductibles, or coinsurance charges incurred by the individual, family, or financially responsible relatives. ( )

b. Expenses incurred by the individual, family, or financially responsible relatives for necessary medical and remedial services not covered under the scope of the Medical Assistance Program. ( )

c. Expenses incurred by the individual, family, or financially responsible relatives for necessary medical and remedial services covered in the scope of the Medical Assistance Program. ( )

d. On a case by case basis, the Department may set reasonable limits on expenses to be deducted from income under Subsections 150.08.a. and 150.08.b. of this rule. ( )

09. Determining Eligibility for Refugee Medical Assistance for Refugees Who Must Meet a "Spend Down." The refugee applicant must provide verification of expenses incurred pursuant to Subsection 150.08 of this rule. If the applicant has medical coverage from a third party, he must verify that charges will not be paid by this third party by providing an Explanation of Benefits or other written statement from the third party. ( )

a. As the applicant submits medical expenses, the charges should be added in the order listed in Subsection 150.08 of this rule. The expenses that come under Subsection 150.08.c. must be put in chronological order by the date of service. ( )

b. When the charges equal or exceed the amount of the "spend down," the applicant becomes eligible for Refugee Medical Assistance. ( )

c. The date of eligibility is the date of service on the last bill which is covered under the scope of the Medical Assistance Program. ( )

d. It is the responsibility of the Department caseworker who is determining the applicant's eligibility to determine when the "spend down" has been met. ( )

10. Issuing a Medical Card to a Refugee Who Must Meet a "Spend Down." A Medical Card will not be issued until the applicant has met the "spend down." The dates on the Medical Card under "Valid Only During" will be the date the applicant becomes eligible for Medicaid benefits "to" the last day of the last month in the quarter for which the "spend down" has been determined. ( )

11. Continued Coverage. If a refugee who is receiving Refugee Medical Assistance receives earnings from employment, the earnings do not affect the refugee's continued eligibility for Refugee Medical Assistance. Once a refugee begins receiving Refugee Medical Assistance, he continues to receive it through his eighth month in the United States. ( )

151. -- 199. (RESERVED).

200. ASSISTANCE TO CUBAN AND HAITIAN ENTRANTS.

01. Eligibility. Except as otherwise provided in Section 200, Refugee Medical Assistance must be provided to Cuban and Haitian entrants under the same conditions, and to the same extent as such assistance is provided to refugees. ( )

02. Period of Eligibility. The number of months during which an entrant may be eligible for Refugee Medical Assistance under the Cuban/Haitian Entrant Program must be counted starting with the first month in which an individual entrant was first issued documentation by the USCIS indicating: ( )

a. The entrant has been granted parole; or ( )

b. The entrant is in voluntary departure status; or ( )

c. The entrant's residence in the United States is known by USCIS. ( )

201. -- 299. (RESERVED).

300. SPONSORSHIP.

01. Providing Name of Resettlement Agency. A refugee must provide the name of his resettlement agency as a condition of eligibility for the Refugee Medical Assistance Program. ( )

02. Resettlement Agency and Sponsor Notification. Whenever a refugee applies for cash or medical assistance for which total or partial reimbursement is provided by the Office of Refugee Resettlement, the Department must promptly notify the resettlement agency (or its local affiliate) that provided for the initial resettlement of the refugee. ( )

03. Contact. In determining a refugee's eligibility for medical assistance, the Field Office must contact the refugee's sponsor or resettlement agency and obtain financial information, including verification of the amount of financial assistance the sponsor or resettlement agency is providing to the refugee. ( )

301. -- 399. (RESERVED).

400. INCOME AND RESOURCES ON DATE OF APPLICATION.
Eligibility is determined using income and resources on the date of application. Income is not averaged over the application processing period. ( )

401. TRANSITION TO REFUGEE MEDICAL ASSISTANCE.
A refugee is transitioned from Medicaid to Refugee Medical Assistance, if he is within eight (8) months following his entry into the United States, and loses Medicaid because of earnings from employment. The transition to Medicaid coverage is made without a Refugee Medical Assistance eligibility determination. In such cases, the income limits under Section 150 of these rules do not apply. ( )

402. -- 599. (RESERVED).

600. RELATIONSHIP TO SUPPLEMENTAL SECURITY INCOME (SSI).
Each refugee who receives Refugee Medical Assistance and is sixty-five (65) or older, or aged, blind, or disabled, must be immediately referred to the Social Security Administration to apply for SSI benefits. ( )

601. -- 699. (RESERVED).

700. OVERPAYMENTS AND RESTORATION OF BENEFITS.
Policy governing recovery of overpayments and restoration of benefits of Refugee Medical Assistance is contained in IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families

and Children." ( )

702. -- 799. (RESERVED).

800. CASE RECORD INFORMATION.
The following information must be recorded in case records of refugees in addition to documentation required by IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." ( )

01. Registration Number. Passport or alien registration number from INA Form I-94; ( )

02. Date of Entry. Month and year of entry into the United States. The receipt of benefits under the Refugee Medical Assistance Program will be limited to eight (8) months from the date of entry into the United States; ( )

03. Nationality. Country in which the refugee was living and fled because of persecution or fear or persecution; ( )

04. Resettlement Agency. Name of the resettlement agency; ( )

05. Sponsor. Name and address of the sponsor; and ( )

06. Initial Settlement. Name(s) of the State(s) from which he moved and in which he initially settled, if a refugee initially settled in another State or States prior to moving to Idaho. ( )

801. -- 994. (RESERVED).

995. PROVISIONS CONTINGENT UPON FEDERAL FUNDING.
The provisions in Sections 000 through 995 of these rules, are contingent upon availability and receipt of funds appropriated through federal legislation. When federal funds are not available to the State of Idaho, these provisions, or any part therein, will not be in force and operation of the Refugee Medical Assistance Program in Idaho will be suspended. Advance notice of termination or reduction of benefits is not required. ( )

996. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.08 - RULES GOVERNING TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO

DOCKET NO. 16-0308-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 proposed. The complete text of the proposed rule was published in Book 1 of the Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 417 through 419.

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 associated with this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Genie Sue Weppner at (208) 334-5656.

DATED this 30th day of October, 2007.

Sherri Kovach
Program Supervisor
DHW - Administrative Procedures Section
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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0308-0701***
Rules Governing Temporary Assistance for Families in Idaho ***PENDING RULE***

THE FOLLOWING NOTICE 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 Wednesday, October 17, 2007.

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 Department proposes to align the methodology used to calculate income for self-employed individuals who apply for Temporary Assistance for Families in Idaho (TAFI) cash assistance with that used in the Food Stamp rules. Use of the same methodology will: (1) simplify the process for determining income for self-employed individuals who are applying for TAFI and Food Stamps, and (2) reduce the opportunity for errors that may occur when different methods are used to determine eligibility for these two programs.

The proposed rule change aligns the methodology for calculating self-employment income for TAFI eligibility with that used in the Food Stamp Program. The new TAFI methodology uses a standard 50% deduction from gross income instead of using gross receipts minus allowable expenses.

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 is no fiscal impact to the state general fund associated with this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted since these rules are being changed to standardize TAFI eligibility determination by aligning the methodology for calculating self-employment income for TAFI eligibility with that used in the Food Stamp Program.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Genie Sue Weppner (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 Wednesday, October 24, 2007.

DATED this 22nd day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

229. ~~*CALCULATION OF*~~ NON-SEASONAL AND SEASONAL SELF-EMPLOYMENT INCOME.
~~*Countable self-employment income is the difference between the gross receipts and the allowable costs of producing the income, if the amount is expected to continue. Self-employment income must be calculated by one (1) of the methods listed in Subsections 229.01 and 229.02.*~~ In determining eligibility for the Temporary Assistance for Families in Idaho (TAFI) Program, the Department counts self-employment business income. ~~*(7-1-98)*~~(____)

01. Non-Seasonal Self-Employ~~*ed*~~ment~~*-at Least One Year*~~. ~~*For individuals who are self-employed for at least one (1) year, income and expenses are averaged over the past twelve (12) months.*~~ If the non-seasonal self-employment is considered annual income by the household, the Department will average the self-employment income over a twelve-month (12) period, even if it is received over a short time period and the household receives income from other sources in addition to self-employment. ~~*(7-1-98)*~~(____)

02. Seasonal Self-Employ~~*ed*~~ment~~*-Less Than One Year*~~. ~~*For individuals who are self-employed for less than one (1) year, income and expenses are averaged over the period of time the business has been in operation.*~~ Seasonally self-employed households only receive income from self-employment during part of the year. If the self-employment income is used to meet the household's needs for only part of the year, the Department will average the seasonal self-employment income over the period of time the income is used. ~~*(7-1-98)*~~(____)

230. DETERMINING THE STANDARD DEDUCTION FOR SELF-EMPLOYMENT ~~*ALLOWABLE EXPENSES*~~ INCOME.
~~*Operating expenses deducted from self-employment income are listed in Subsections 230.01 through 230.16.*~~ The Department determines net self-employment income for a business by subtracting fifty percent (50%) from the gross income as an allowable standard deduction for self-employment income. ~~*(7-1-98)*~~(____)

~~***01. Labor****. Labor paid to individuals not in the family.* *(7-1-98)*~~

~~***02. Materials****. Materials such as stock, seed and fertilizer.* *(7-1-98)*~~

~~***03. Rent****. Rent on business property.* *(7-1-98)*~~

~~***04.*** ***Interest****. Interest paid to purchase income producing property.* *(7-1-98)*~~

~~***05.*** ***Insurance****. Insurance paid for business property.* *(7-1-98)*~~

~~***06.*** ***Taxes****. Taxes on income producing property.* *(7-1-98)*~~

~~***07.*** ***Business Transportation****. Business transportation as defined by the IRS.* *(7-1-98)*~~

~~***08.*** ***Maintenance****. Landscape and grounds maintenance.* *(7-1-98)*~~

~~***09.*** ***Lodging****. Lodging for business related travel.* *(7-1-98)*~~

~~***10.*** ***Meals****. Meals for business related travel.* *(7-1-98)*~~

~~***11.*** ***Use of Home****. Costs of partial use of home for business.* *(7-1-98)*~~

~~***12.*** ***Legal****. Legal fees for business related issues.* *(7-1-98)*~~

~~***13.*** ***Shipping****. Shipping for business related costs.* *(7-1-98)*~~

~~***14.*** ***Uniforms****. Business related uniforms.* *(7-1-98)*~~

~~***15.*** ***Utilities****. Utilities for business property.* *(7-1-98)*~~

~~***16.*** ***Advertising****. Business related advertising.* *(7-1-98)*~~

231. DETERMINING SELF-EMPLOYMENT ~~*EXPENSES NOT ALLOWED*~~ INCOME. ~~*Self-employment expenses not allowed are listed in Subsections 231.01 through 231.09.*~~ The Department determines self-employment income by adding projected monthly income to projected capital gains and subtracting the standard deduction for self-employment income. ~~*(7-1-98)*~~(____)

01. ~~*Payments on the Principal of Real Estate*~~ Determination of Gross Monthly Income. ~~*Payments on the principal of real estate mortgages on income-producing property.*~~ If no income fluctuations are expected, the Department will project the average gross monthly income for the certification period. If past income is not reflective of expected future income, the Department will make a proportionate adjustment to the expected gross monthly income. The Department will determine the gross monthly income of a self-employed person using one (1) of the following: ~~*(7-1-98)*~~(____)

a. If tax returns are available, the information on the return will be used to determine an appropriate average gross monthly income amount. The Department will verify that the tax return reflects a full twelve (12) months of self-employment; or (____)

b. If no tax return is available, the self-employment income will be averaged over the period of time the self-employment business enterprise has been in operation. (____)

02. ~~*Purchase of*~~ Addition of Monthly Capital ~~*Assets or Durable Goods*~~ Gains

Income. ~~*Purchases of capital assets, equipment, machinery, and other durable goods. Payments on the principal of loans for these items.*~~ Capital gains include profit from the sale or transfer of capital assets used in self-employment. ~~*(7-1-98)*~~(____)

a. The Department will calculate capital gains using the federal income tax method; (____)

b. The Department will determine if the household expects to receive any capital gains income from self-employment assets during the certification period; and (____)

c. The Department will add this amount to the monthly income to determine the gross monthly income, in accordance with Subsection 231.01 of this rule. (____)

03. ~~***Taxes***~~ **Subtraction of the Standard Deduction for Self-Employment Income**. ~~*Federal, state, and local income tax.*~~ The Department will subtract fifty percent (50%) of the gross monthly income as a standard deduction for self-employment income. This is the projected self-employment monthly income. ~~*(7-1-98)*~~(____)

~~***04.*** ***Savings****. Monies set aside for future use such as retirement or work related expenses.* *(7-1-98)*~~

~~***05.*** ***Depreciation****. Depreciation for equipment, machinery, or other capital investments.* *(7-1-98)*~~

~~***06.*** ***Labor Paid to Family Member****. Labor paid to a family member.* *(7-1-98)*~~

~~***07.*** ***Loss of Farm Income****. Loss of farm income deducted from other income.* *(7-1-98)*~~

~~***08.*** ***Personal Transportation****. Personal transportation.* *(7-1-98)*~~

~~***09.*** ***Net Losses****. Net losses from previous periods.* *(7-1-98)*~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 56-257, Idaho Code; also House Bill 663aa (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 January 3, 2007, Idaho Administrative Bulletin, Vol. 07-1, pages 149 through 151.

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 co-payments by participants is cost-neutral to the Medicaid budget:

1. **Co-payments are paid by the participant to the provider, not to the Medicaid program; and**

2. **Co-payments are permissive (i.e., providers may, but are not required, to charge the co-payment) and there is no reduction in provider payment by Medicaid when a participant pays the co-payment.**

Future savings may be realized as participants make better choices and reduce inappropriate use of services.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Patti Campbell at (208) 287-1158.

DATED this 5th day of September, 2007.

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0309-0701***
Medicaid Basic Plan Benefits ***PENDING RULE***

Sherri Kovach
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is February 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 rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), and 56-257, Idaho Code; also House Bill 663aa (2006), and the federal Deficit Reduction Act of 2005; P.L. 109-171.

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

Date:	**Thursday, January 11, 2007**	**Tuesday, January 16, 2007**	**Tuesday, January 23, 2007**
Time:	**7:00 p.m.**	**5:30 p.m.**	**7:00 p.m.**
Place:	**DHW - Region I Office** **1120 Ironwood Drive** **Suite 102** **Coeur d'Alene, ID**	**DHW - Region IV Office** **1720 Westgate Dr.** **Suite D, Room 119** **Boise, ID**	**Idaho Falls Public Library** **457 Broadway** **Library Conference Room** **Idaho Falls, 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 Department is establishing cost-sharing measures for Medicaid participants in order to comply with House Bill 663 passed by the 2006 Legislature. The purpose of the statute and of this rule change is two-fold:

1. **To increase awareness and responsibility of Medicaid participants regarding the cost of their health care, and**

2. To encourage them to use cost-effective care in the most appropriate setting.

To accomplish this purpose, the new cost-sharing measures can require participants to pay for part of the cost of Medicaid services, in the form of a co-payment, when they have accessed those services inefficiently or inappropriately. A reference to IDAPA 16.03.18, "Medicaid Cost-Sharing," is also being added. Companion rule changes in that chapter describe the actual amounts of each co-payment (see Docket No. 16-0318-0701).

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is needed to comply with deadlines in amendments to governing law or federal programs (see House Bill 663aa, 2006).

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 co-payments by participants is cost-neutral to the Medicaid budget:

1. **Co-payments are paid by the participant to the provider, not to the Medicaid program; and**

2. **Co-payments are permissive (i.e., providers may, but are not required, to charge the co-payment) and there is no reduction in provider payment by Medicaid when a participant pays the co-payment.**

Future savings may be realized as participants make better choices and reduce inappropriate use of services.

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 Patti Campbell at (208) 287-1158.

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, January 24, 2007.

DATED this 14th day of November, 2006.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

151. -- 1~~9~~59. (RESERVED).

160. RESPONSIBILITY FOR KEEPING APPOINTMENTS.
The participant is solely responsible for making and keeping an appointment with the provider. If a participant makes an appointment and subsequently does not keep it, the participant may be required to pay the provider an amount established by the provider's missed appointment policy that is applicable to all patients of the provider. (____)

161. -- 164. (RESERVED).

165. COST-SHARING.

01. Co-Payments. When a participant accesses certain services inappropriately, the provider can require the participant to pay a co-payment as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (____)

02. Premiums. A participant can be required to share in the cost of basic plan benefits in the form of a premium as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (____)

166. -- 199. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

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

03. Co-Payments. (____)

a. When an emergency room physician conducts a medical screening and determines that an emergency condition does not exist, the hospital can require the participant to pay a co-payment as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (____)

b. A hospital may refuse to provide services to a participant when a medical screening has determined that an emergency condition does not exist and the participant does not make the required co-payment at the time of service. Under these circumstances, the hospital must provide notification to the participant as specified in Section 1916A(e) of the Social Security Act. ( )

(BREAK IN CONTINUITY OF SECTIONS)

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

04. Co-Payments. When the Department determines that the participant did not require emergency transportation, the provider can bill the participant for the co-payment amount as described in IDAPA 16.03.18, “Medicaid Cost-Sharing.” ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0702

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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), 56-203(i), 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 Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 420 through 423.

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 to the state general fund related to this rulemaking since the proposed rule amendments simply describe, but do not alter, the current methodology used to set Federally Qualified Health Center (FQHC) reimbursement rates.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sheila Pugatch at (208) 364-1817.

DATED this 5th day of November, 2007.

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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0309-0702***
Medicaid Basic Plan Benefits ***PENDING RULE***

THE FOLLOWING NOTICE 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), 56-203(g), and 56-257, 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 17, 2007.

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 defines and describes the methodology used by the Department to determine reimbursement rates for new and existing Federally Qualified Health Centers (FQHCs), including when they make changes in the scope of services they provide.

In this rulemaking, the term "change in the scope of services" refers to such things as the addition of new services, deletion of existing services, or other changes in the scope or intensity of services offered by an FQHC that could change the maximum amount an FQHC may charge for each patient visit.

This rulemaking was done at the request of primary care industry stakeholders.

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 is no anticipated fiscal impact to the state general fund related to this rulemaking since the proposed rule amendments simply describe, but do not alter, the current methodology used to set FQHC reimbursement rates.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted on Monday, June 11, 2007, with representatives of the Idaho Primary Care Association. The Notice of Negotiated Rulemaking was published in the Wednesday, June 6, 2007, Idaho Administrative Bulletin, Vol. 07-6, page 68.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sheila Pugatch at (208) 364-1817.

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 24, 2007.

DATED this 15th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

830. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES - DEFINITIONS.

01. **Change in Intensity of Services of an FQHC**. A change in the intensity of services of an FQHC means a change in the quantity and complexity of services delivered that could change an FQHC's total allowable cost per encounter. This does not include an expansion or remodeling of an existing FQHC. This may include such things as the addition of new services or the deletion of existing services. ( )

02. **Encounter**. An encounter, for FQHC payment purposes, is a face-to-face contact for the provision of medical/mental or dental services between a FQHC patient and a provider as specified in Subsections 832.01 through 832.07 of these rules. For the purposes of establishing encounter rates, the term “medical/mental” refers to a single category of service. ( )

03. **Encounter Rate**. An encounter rate can be of two (2) types, either medical/mental or dental; either of these two (2) types can be either an interim rate or a finalized rate. An encounter rate is the total amount of annual costs for the type of encounter divided by the total number of encounters for that type of encounter for the FQHC’s fiscal year. ( )

a. Interim Encounter Rate. If the FQHC is new and historical cost information is not available, the Department sets the interim encounter rate using budgeted cost and encounter information submitted by the provider. If the FQHC is not able to obtain its financial budget information, the Department sets the interim encounter rate by referring to encounter rates paid to other FQHCs in the same or adjacent regional areas with similar caseloads. ( )

b. Finalized Encounter Rate. If the FQHC is an existing facility and has at least twenty-four (24) consecutive months of historical cost and encounter information, the Department uses the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. ( )

04. **Federally Qualified Health Centers (FQHCs)**. 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, and outpatient health programs or clinics operated by a tribe or

tribal organization under the Indian Self-Determination Act (P.L. 93-638)~~,~~. ~~*and*~~ It also includes clinics that qualify for, but are not actually receiving, grant funds according to Sections 329, 330, or 340 of the Public Health Service Act (42 USC Sections 201, et seq.) that may provide ambulatory services to medical assistance participants. ~~*(3-30-07)*~~( )

05. **Medicare Cost Report Period**. The period of time covered by the Medicare-required annual report of an FQHC's costs. ( )

06. **Medicare Economic Index (MEI)**. MEI is an annual measure of inflation designed to estimate the increase in the total cost for the average physician to operate a medical practice. The MEI takes into account cost categories such as a physician's own time, non-physician employees' compensation, rents, and medical equipment. The MEI is used in establishing the annual changes to the payment conversion factors used as part of the methodology for determining FQHC reimbursement rates. ( )

(BREAK IN CONTINUITY OF SECTIONS)

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(bb), Subsections (1) through (4). (3-30-07)

02. **FQHC Encounter Limitations and Exceptions**. ~~*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.*~~ FQHC encounters have the following limitations and exceptions to these limitations as described in Subsections 835.02.a. through 835.02.d. of this rule: ~~*(3-30-07)*~~( )

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~~,~~ or dental) on the same day is one (1) encounter. ~~*(3-30-07)*~~( )

b. Reimbursement for services is limited to three (3) encounters per participant per day. (3-30-07)

c. As an exception to Subsection 835.02.a. of ~~*these*~~ this rule~~*s*~~, a second encounter with the same professional on the same day may be reimbursed; or ~~*(3-30-07)*~~( )

d. As an exception to Subsection 835.02.b. of ~~*these*~~ this rule~~*s*~~, 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. ~~*(3-30-07)*~~( )

836. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES - RATE SETTING METHODOLOGY.

01. Prospective Payment System. ( )

a. For rate periods beginning on January 1, 2001, the Department will establish separate, finalized rates for medical/mental encounters and for dental encounters. The Department will prospectively set these finalized encounter rates using the FQHC's medical/mental and dental encounter costs. ( )

b. Beginning in federal fiscal year 2002, and for each federal fiscal year thereafter, the Department will pay each FQHC an encounter rate equal to the amount paid in the previous federal fiscal year. For the period starting with federal fiscal year 2002 and thereafter, the Department will adjust the encounter rate for inflation using the Medicaid Economic Index (MEI), as published by CMS. For both medical/mental encounters and dental encounters, FQHCs are paid on a per encounter basis, with the limitations and exceptions described under Subsection 835.02 of these rules. ( )

c. If an out-of-state FQHC becomes an Idaho Medicaid provider and provides less than one hundred (100) Idaho Medicaid encounters or receives less than ten thousand dollars ($10,000) in Idaho Medicaid payments in the first year after entering the program, the Department will deem the FQHC a low utilization provider. The finalized encounter rate for low utilization providers will be the same as the interim encounter rate as defined in Subsection 836.02.a. of this rule. If there is an increase in either the number of encounters or in the amount of payments over any twelve (12) month Medicare cost report period, the Department reserves the right to audit a low utilization provider's Medicare cost report in order to set a new interim encounter rate as defined in Subsection 836.02.a. of this rule. ( )

02. FQHCs That Become Idaho Medicaid Providers. ( )

a. If the FQHC is new and encounter rate information for other FQHCs in the same or adjacent regional areas with similar caseloads is not available, the Department will set the interim encounter rate using historical cost information. If historical cost information is not available, the Department will use budgeted cost and encounter information submitted by the provider. If the FQHC is not able to provide its financial budget information, the Department will set the interim encounter rate by referring to encounter rates paid to other FQHCs in the same or adjacent regional areas with similar caseloads. Regional areas are defined by the Department. ( )

b. If the FQHC has been designated as an FQHC for at least twenty-four (24) consecutive months and provides the historical cost and encounter information for this period to the Department, the Department will use the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. The Department will provide the FQHCs a supplemental information worksheet to complete. This worksheet will be used by the Department to identify dental encounters and other incidental costs related to either medical/mental or dental FQHC encounters. ( )

c. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will audit the Medicare cost report for the twenty-four (24) consecutive months that represent two (2) complete fiscal years after the FQHC has become a Medicaid provider. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. ( )

d. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will adjust the finalized encounter rate annually for inflation in accordance with Subsection 836.01.b. of this rule. ( )

e. The Department will adjust the claim payments for all FQHC claims paid at the interim encounter rate(s). These adjustments will reflect the payment at the finalized encounter rate(s). The Department will pay the FQHC for any total adjustment amount over what was reimbursed. The FQHC must pay the Department for any total adjustment amount that is under what was reimbursed. ( )

03. Change in an FQHC Encounter Rate Due to a Change in the FQHC's Scope of Services. ( )

a. After an FQHC obtains approval for a change in scope of service from the federal Human Resources and Services Administration (HRSA), Bureau of Primary Healthcare, the FQHC must request the Department to review the encounter rate(s) for the FQHC. The review will include reviewing the addition of a new service(s), deletion of an existing service(s), or other changes in the intensity of services offered by an FQHC that could change an FQHC's total cost per encounter. The FQHC must request the Department to review the encounter rate(s) within sixty (60) days after the FQHC has gained approval from the HRSA Bureau of Primary Health Care for a change in scope of service. The Department requires the same supporting documentation required by the HRSA Bureau of Primary Health Care. ( )

b. When an FQHC does not have to file a change in scope of service with the HRSA Bureau of Primary Health Care, but plans an increase or decrease in the intensity of services to be offered that will result in a change the FQHC's scope of services, the FQHC must request the Department to review the request for a change in intensity and determine if there will be an increase or decrease in the encounter rate(s) for the FQHC. The Department will review the request for a change in intensity within 60 (sixty) days of the planned change in intensity of services. ( )

c. The Department reserves the right to audit the Medicare cost report and recalculate the encounter rates when the FQHC has reported a change in scope of service. ( )

d. The Department will determine the encounter rate in accordance with Subsection 836.02 of this rule when the FQHC has reported a change in scope of service. The Department will audit and cost settle the most recent twenty-four (24) consecutive months of Medicare cost reports following any change(s) in an FQHC's scope of service. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. The finalized encounter rate(s) for both medical/mental and dental encounters will be recalculated and audited using the Medicare cost report for the second full twelve (12) month period. ( )

04. **Annual Filing Requirements**. Each provider is required to file a copy of its Medicare cost report on an annual basis. Department deadlines are the same as those imposed by Medicare. ( )

05. **Quarterly Supplemental Payments**. In the case of any FQHC that contracts with a managed care organization, the Department will make quarterly supplemental payments to the FQHC for the difference between the payment amounts paid by the managed care organization and the amount to which the FQHC is entitled under the prospective payment system for Medicaid participants. ( )

83~~6~~7. -- 841. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0703

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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), 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 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 Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 424 through 427.

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 Sheila Pugatch at (208) 364-1817.

DATED this 5th day of November, 2007.

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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0309-0703***
Medicaid Basic Plan Benefits ***PENDING RULE***

THE FOLLOWING NOTICE 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), 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.

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 17, 2007.

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 revises the definition to clarify that the floor calculation for hospitals with more than forty beds is 81.5% of Medicaid costs, and the floor calculation for hospitals with forty or fewer beds is 96.5% of Medicaid costs.

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: Informal negotiated rulemaking was conducted on May 2, 2007 with the Nursing Home Prospective Payment System Oversight Committee.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sheila Pugatch at (208) 364-1817.

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 24, 2007.

DATED this 15th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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. (3-30-07)

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. (3-30-07)

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. (3-30-07)

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. (3-30-07)

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. (3-30-07)

06. Charity Care. Charity care is care provided to individuals who have no source of payment, third- party or personal resources. (3-30-07)

07. Children's Hospital. A Medicare-certified hospital as set forth in 42 CFR Section 412.23(d). (3-30-07)

08. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (3-30-07)

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. (3-30-07)

10. 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. (3-30-07)

11. 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. (3-30-07)

12. Disproportionate Share Threshold. The disproportionate share threshold is: (3-30-07)

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (3-30-07)

b. A Low Income Revenue Rate exceeding twenty-five percent (25%). (3-30-07)

13. 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. (3-30-07)

14. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. (3-30-07)

15. Low Income Revenue Rate. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (3-30-07)

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 (3-30-07)

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. (3-30-07)

16. 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. (3-30-07)

17. 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. (3-30-07)

18. 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. (3-30-07)

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). (3-30-07)

20. 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. (3-30-07)

21. 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. (3-30-07)

22. Principal Year. The principal year is the period from which the Medicaid Inpatient Operating Cost Limit is derived. (3-30-07)

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. (3-30-07)

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.

(3-30-07)

23. 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. (3-30-07)

24. 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. (3-30-07)

25. 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%).*~~ The floor calculation for hospitals with more than forty (40) beds is eighty-one and a half percent (81.5%) of Medicaid costs, and the floor calculation for hospitals with forty (40) or fewer beds is ninety-six and a half percent (96.5%). ~~*(3-30-07)*~~( )

26. TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. (3-30-07)

27. 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. (3-30-07)

28. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0704

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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), 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 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 Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 428 through 430.

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 Jeanne Siroky at (208) 364-1897.

DATED this 5th day of November, 2007.

Sherri Kovach
Program Supervisor
DHW – Administrative Procedures Section
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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0309-0704***
Medicaid Basic Plan Benefits ***PENDING RULE***

THE FOLLOWING NOTICE 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), 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.

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 17, 2007.

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:

Because of newer technology and surgical procedures, surgically implantable hearing aids are becoming more common. The Department is adding new language to this rule stating the circumstances under which a surgically implanted hearing aid will be authorized. This rule change will state that authorization and coverage for the surgically implanted hearing aid will occur only after there is documented evidence that a non-implantable hearing aid cannot meet the medical needs of the participant. Also, a rule citation is being updated in the Early Periodic Screening, Diagnosis and Treatment Services (EPSDT) section of rule relating to hearing aids.

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 this rulemaking simply clarifies the procedures for prior authorization of a piece of medical equipment that is already being provided.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jeanne Siroky at (208) 364-1897.

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 24, 2007.

DATED this 20th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

742. AUDIOLOGY SERVICES - COVERAGE AND LIMITATIONS.
The Department will pay for audiometric services and supplies in accordance with the following guidelines and limitations: (3-30-07)

01. **Non-Implantable Hearing Aids**. When there is a documented hearing loss of at least thirty (30) decibels based on the standard Pure Tone Average (500, 1000, 2000 hertz), ~~T~~the Department will cover the purchase of one (1) non-implantable hearing aid per participant per lifetime with the following requirements and limitations: ~~(3-30-07)~~(____)

~~**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.* (3-30-07)~~

~~**b**~~**a.** 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. (3-30-07)

~~**c**~~**b.** 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. (3-30-07)

~~**d**~~**c.** 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. (3-30-07)

02. **Implantable Hearing Aids**. The Department may cover a surgically implantable hearing aid when: (____)

a. There is a documented hearing loss as described in Subsection 742.01 of this rule; (____)

b. Non-implantable options have been tried, but have not been successful; and(____)

c. The Department has determined that a surgically implanted hearing aid is

medically necessary through the prior authorization process. The Department will consider the guidelines of private and public payors, evidence-based national standards or medical practice, and the medical necessity of each participant's case. ( )

03. **Provider Documentation Requirements**. The following information must be documented and kept on file by the provider: ( )

a. The participant's diagnosis; ( )

b. 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; and ( )

c. The brand name and model type of the hearing aid needed. ( )

04. **Allowance to Waive Impedance Test**. The Department will allow a medical doctor to waive the impedance test based on his documented judgment. ( )

(BREAK IN CONTINUITY OF SECTIONS)

882. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES (EPSDT) SERVICES - COVERAGE AND LIMITATIONS.

01. **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. (3-30-07)

02. **Services Must Be Medically Necessary**. The need for additional services must be documented by the attending physician as medically necessary. (3-30-07)

03. **Prior Authorization**. 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. (3-30-07)

04. **Services Not Covered**. The Department will not cover services for cosmetic, convenience, or comfort reasons. (3-30-07)

05. **Hearing Aids Under EPSDT**. (3-30-07)

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. (3-30-07)

b. When replacement hearing aids are requested, they may be authorized if the

requirements in Subsections 74~~1~~2.01.a., ~~*through*~~ 74~~1~~2.01.~~*d*~~b., and 742.03 are met. ~~*(3-30-07)*~~( )

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. (3-30-07)

06. Eyeglasses Under EPSDT. (3-30-07)

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. (3-30-07)

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. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0705

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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), 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 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 Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 431 through 436.

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 Robin Pewtress at (208) 364-1892.

DATED this 5th day of November, 2007.

Sherri Kovach
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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0309-0705***
Medicaid Basic Plan Benefits ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 1, 2007.

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

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

Wednesday, October 10, 2007 -- 4:00 p.m.
Division of Medicaid
Conference Room "D" East
3232 Elder 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 a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking adds a Chronic Disease Management benefit for Medicaid participants with certain chronic diseases. The benefit will be phased in and the specific diseases will initially include: diabetes; asthma; hypertension; hyperlipidemia, and depression.

Primary care providers who participate in the Healthy Connections program and who also enroll in the Chronic Disease Management program receive an enhanced case management fee for effectively managing their Medicaid patients' chronic disease. To receive the enhanced fee, the provider must identify the patients with the targeted disease and report specified evidence-based quality indicators to the Department. The required reporting criteria differ by disease and are determined by the Department. This rulemaking adds the methodology for determining the reporting requirements for each chronic disease.

Additionally, this rulemaking removes the requirement that a Healthy Connections referral must be made for the following services: anesthesiology services, laboratory (including pathology), and radiology services.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)c, Idaho Code, the Governor has found that temporary adoption of the rule confers a benefit to Medicaid participants because it is beneficial to their health outcomes.

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 this rulemaking confers a benefit to Medicaid participants.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Robin Pewtress at (208) 364-1892.

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 24, 2007.

DATED this 22nd day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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: (3-30-07)

01. **Best Practices Protocol**. A regimen of proven, effective and evidence-based practices. ( )

02. **Chronic Disease Management**. The process of applying best practices protocol to manage a chronic disease in order to produce the best health outcomes for a participant with the targeted chronic disease. ( )

0~~1~~3. **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. (3-30-07)

0~~2~~4. **Covered Services**. Those medical services and supplies for which reimbursement is available under the State Plan. (3-30-07)

0~~3~~5. **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. (3-30-07)

0~~4~~6. 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.~~"~~ Healthy Connections is a primary care case management model. ~~(3-30-07)~~(____)

~~**05. Plan**. The area specific provisions, requirements and procedures related to Healthy Connections. (3-30-07)~~

07. Pay-for-Performance. The use of incentives to encourage and reinforce the delivery of evidence-based practices that promote better outcomes as efficiently as possible. (____)

0~~6~~8. Primary Care Case Management. The process in which a ~~*physician*~~ primary care provider 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. ~~(3-30-07)~~(____)

0~~7~~9. Primary Care ~~*Case Manager*~~ Provider (PCP). A ~~*primary care physician*~~ qualified medical professional who contracts with Medicaid to coordinate the care of certain participants. ~~(3-30-07)~~(____)

~~08~~10. Qualified Medical Professional. 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. (3-30-07)

~~09~~11. 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. (3-30-07)

12. Targeted Chronic Disease. One (1) of the diseases included in the chronic disease management pay-for-performance program. The specific targeted chronic diseases are diabetes, asthma, hypertension, hyperlipidemia, and depression. The Department may change the diseases included in the program after appropriate notification to PCPs. (____)

561. HEALTHY CONNECTIONS - PARTICIPANT ELIGIBILITY.

01. Voluntary County. In a ~~*voluntary*~~ county where participation in Healthy Connections is voluntary, the participant will be given an opportunity to choose a ~~*primary care provider*~~ PCP. 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. ~~(3-30-07)~~(____)

02. Mandatory County. In a ~~*mandatory*~~ county where participation in Healthy Connections is mandatory, a ~~*provider*~~ PCP 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: ~~*(3-30-07)*~~(____)

a. Have to travel more than thirty (30) miles, or thirty (30) minutes to obtain primary care services; (3-30-07)

b. Have an eligibility period that is less than three (3) months; (3-30-07)

c. Have an eligibility period that is only retroactive; (3-30-07)

d. Are eligible only as Qualified Medicare Beneficiary; (3-30-07)

e. Have an existing relationship with a primary care physician or clinic who is not participating with the Healthy Connections; or (3-30-07)

f. Has incompatible third party liability. (3-30-07)

g. Are enrolled in the Medicare/Medicaid Coordinated Plan. (____)

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: (3-30-07)

a. Family planning services; (3-30-07)

b. Emergency care (as defined by the Department for the purpose of payment and performed in an emergency department); (3-30-07)

c. Dental care ~~*(performed in the office)*~~; ~~*(3-30-07)*~~(____)

d. Podiatry (performed in the office); (3-30-07)

e. Audiology (hearing tests or screening, does not include ear/nose/throat services); (3-30-07)

f. Optical/Ophthalmology/Optometrist services (performed in the office); (3-30-07)

g. Chiropractic (performed in the office); (3-30-07)

h. Pharmacy (prescription drugs only); (3-30-07)

i. Nursing home; (3-30-07)

j. ICF/MR services; (3-30-07)

k. ~~*Childhood i*~~Immunizations (not requiring an office visit); ~~*(3-30-07)*~~(____)

l. Flu shots and/or pneumococcal vaccine (not requiring an office visit); (3-30-07)

m. Diagnosis and/or treatment for sexually transmitted diseases; (3-30-07)

n. One screening mammography per calendar year for women age forty (40) or older; (3-30-07)

o. Indian Health Clinic/638 Clinic services provided to individuals eligible for Indian Health Services; ~~*and*~~ ~~*(3-30-07)*~~(____)

p. In-home services, known as Personal Care Services and Personal Care Services Case Management~~.~~; ~~*(3-30-07)*~~(____)

q. Laboratory services, including pathology; (____)

r. Anesthesiology services; and (____)

s. Radiology services. (____)

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. (3-30-07)

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*~~ PCP. 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. ~~*(3-30-07)*~~(____)

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. (3-30-07)

b. Changing ~~*Providers*~~ PCPs. If a participant is dissatisfied with his ~~*provider*~~ PCP, he may change providers effective the first day of any month by contacting 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. ~~*(3-30-07)*~~(____)

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*~~ PCPs, and may obtain a referral from their ~~*primary care provider*~~ PCP pending the

transfer. Such referrals are valid not to exceed thirty (30) days. ~~(3-30-07)~~(____)

02. Problem Resolution. (3-30-07)

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 . (3-30-07)

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*~~ program and function as a liaison between participants and providers. It is anticipated that most problems and complaints will be resolved informally at this level. ~~(3-30-07)~~(____)

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. (3-30-07)

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. (3-30-07)

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. (3-30-07)

03. Chronic Disease Management Registration. A participating PCP must initially register each participant eligible for chronic disease management reimbursement with the Department. (____)

04. Chronic Disease Management Reporting. A participating PCP must annually report on all identified quality indicators for each targeted chronic disease that he seeks reimbursement as specified in the provider agreement. The reporting schedule is established by the Department in the provider agreement. (____)

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. (3-30-07)

02. Provider Participation Conditions and Restrictions. (3-30-07)

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. (3-30-07)

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. Providers participating in the chronic disease management pay-for-performance program must sign an addendum to the primary care case management provider agreement. ~~*(3-30-07)*~~(____)

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. (3-30-07)

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. (3-30-07)

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*~~ PCP, the provider must transfer (if a request is made) a copy of the patient's medical record to the new ~~*provider*~~ PCP. Provider must also disclose information required by Subsection 205.01 of these rules, when applicable. ~~*(3-30-07)*~~(____)

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. (3-30-07)

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.*~~ ~~*(3-30-07)*~~

01. Case Management Fee. Reimbursement is as follows: (____)

a. PCPs will be paid a case management fee for primary care case management services. ( )

b. PCPs enrolled in the chronic disease management pay-for-performance program will be paid an enhanced case management fee. ( )

c. The amount of the fees is determined by the Department and specified in the provider agreement. ( )

d. The amount of the fee is fixed and the same for all participating PCPs. ( )

02. Primary Care Case Management. Reimbursement is based on the number of participants enrolled under the provider on the first day of each month multiplied by the amount of the case management fee. ( )

03. Chronic Disease Management. Reimbursement is based on: ( )

a. The number of participants who have a targeted chronic disease multiplied by the amount of the enhanced case management fee for patient identification; and ( )

b. The number of instances that the PCP achieved Department specified best practices protocol for the disease being managed multiplied by the amount of the enhanced case management fee for reported quality indicators. ( )

566. HEALTHY CONNECTIONS - QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of Chronic Disease Management. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. ( )

56~~6~~7. -- 569. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0706

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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), 56-203(i), 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 Department has reviewed and given due consideration to the public comments submitted for this rule. The comments expressed several concerns including new requirements for prior authorization of speech therapy and occupational therapy, a plan for reviewing the requests for prior authorization, the potential for increased cost to the state, as well as the increased potential for fraud and abuse.

The Department worked closely with the Idaho Occupational Therapy Association and the Idaho Speech and Hearing Association to develop rules that will increase access and ensure that participants will receive the right care at the right time, and, at the same time, prevent over-utilization of therapy services. The Department has conducted research on expected utilization, and there are processes in place to achieve the added responsibilities in a timely manner and to monitor for over-utilization. The Department is not requesting any changes to the proposed rule.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in Book 1 of the Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 437 through 452.

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:

This rule change requires updates to Medicaid's automated billing system estimated to cost $125,000. However, no net increase in trustee and benefit costs are anticipated as a result of this rule change.

No new services will be implemented with this rule change. Rather, a new provider type

will be allowed to bill for therapy services. The improved access to therapy services that may result from this change may increase utilization of these services. However, the proposed rule change also sets new limits on the amount of therapy services that can be provided without prior authorization. It is anticipated that the increased access to therapy services in conjunction with limitations on therapy visits as a result of the prior authorization review will off-set each other.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jeanne Siroky at (208) 364-1897.

DATED this 5th day of November, 2007.

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@dhw.idaho.gov e-mail

THE FOLLOWING NOTICE 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), 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.

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

Tuesday, October 16, 2007	**Wednesday, October 17, 2007**	**Tuesday, October 23, 2007**
6:00 p.m.	**6:00 p.m.**	**6:00 p.m.**
DHW - Region I Office	**DHW - Region IV Office**	**DHW - Human Development Ctr**
1120 Ironwood Drive, Suite 102	**1720 Westgate Drive**	**421 Memorial Drive**
Coeur d'Alene, ID	**Suite D, Room 119, Boise, ID**	**Pocatello, 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 Idaho Occupational Therapy Association and the Idaho Speech and Hearing

Association reported to the Department that in some areas of the state, occupational therapy and speech-language pathology services are in short supply, resulting in long waiting lists for Medicaid participants. This situation is due, in part, to the fact that occupational therapists and speech-language pathologists cannot bill Medicaid directly for their services. This has resulted in a shortage of providers, especially in rural areas, as some professionals move to other states that allow them to set up their own businesses and bill those Medicaid programs directly. Currently, the waiting time for children to obtain needed speech and occupational therapy ranges from two weeks to nine months across the state.

These rule changes are being proposed to improve access to therapy services for Medicaid participants while setting reasonable limits on these services.

These rule changes:

1. **Allow occupational therapists and speech-language pathologists to become Medicaid providers and bill Medicaid directly resulting in improved participant access to these services;**

2. **Allow Home Health Agencies to bill for speech-language pathology services provided to participants in their homes; and**

3. **Limit a participant's occupational therapy to 25 visits and speech-language pathology services to 40 visits per calendar year without prior authorization. More visits can be prior authorized when medically necessary.**

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.

This rule change requires updates to Medicaid's automated billing system estimated to cost $125,000. However, no net increase in trustee and benefit costs are anticipated as a result of this rule change.

No new services will be implemented with this rule change. Rather, a new provider type will be allowed to bill for therapy services. The improved access to therapy services that may result from this change may increase utilization of these services. However, the proposed rule change also sets new limits on the amount of therapy services that can be provided without prior authorization. It is anticipated that the increased access to therapy services in conjunction with limitations on therapy visits as a result of the prior authorization review will off-set each other.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, informal negotiated rulemaking was conducted in the development of these rule changes. The groups involved in the negotiated rulemaking were: Idaho Occupational Therapy Association, Idaho Speech and Hearing Association, and the Idaho Physical Therapy Association.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jeanne Siroky at (208) 364-1897.

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 24, 2007.

DATED this 23rd day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

012. DEFINITIONS -- P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-30-07)

01. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-30-07)

02. Patient. The person undergoing treatment or receiving services from a provider. (3-30-07)

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. (3-30-07)

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." (3-30-07)

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. (3-30-07)

06. Private Rate. Rate most frequently charged to private patients for a service or item. (3-30-07)

07. PRM. Provider Reimbursement Manual. (3-30-07)

08. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-30-07)

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: (3-30-07)

a. Artificially replace a missing portion of the body; or (3-30-07)

b. Prevent or correct physical deformities or malfunctions; or (3-30-07)

c. Support a weak or deformed portion of the body. (3-30-07)

d. Computerized communication devices are not included in this definition of a prosthetic device. (3-30-07)

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. (3-30-07)

11. Provider Agreement. A written agreement between the provider and the Department, entered into in accordance with Section 205 of these rules. (3-30-07)

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. (3-30-07)

13. Prudent Layperson. A person who possesses an average knowledge of health and medicine. (3-30-07)

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." (3-30-07)

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. (3-30-07)

16. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-30-07)

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). (3-30-07)

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. (3-30-07)

19. R.N. Registered Nurse, which in the State of Idaho is known as a Licensed

Professional Nurse. (3-30-07)

20. Rural Health Clinic (RHC). An outpatient entity that meets the requirements of 42 USC 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. (3-30-07)

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. (3-30-07)

22. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons who meet certain criteria. (3-30-07)

~~***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. (3-30-07)~~

2~~4~~3. State Plan. The contract between the state and federal government under 42 USC Section 1396a(a). (3-30-07)

2~~5~~4. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-30-07)

2~~6~~5. Title XVIII. Title XVIII of the Social Securty Act, known as Medicare, for aged, blind, and disabled individuals administered by the federal government. (3-30-07)

2~~7~~6. 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. (3-30-07)

2~~8~~7. 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. (3-30-07)

2~~9~~8. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. (3-30-07)

~~30~~29. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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," are also eligible for the services covered under this chapter of rules, unless specifically exempted. (3-30-07)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 447 of these rules. (3-30-07)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 456 of these rules. (3-30-07)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 516 of these rules. (3-30-07)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 556 of these rules. (3-30-07)

a. Midlevel practitioner services are described in Sections 520 through 526. (3-30-07)

b. Chiropractic services are described in Sections 530 through 536. (3-30-07)

c. Podiatrist services are described in Sections 540 through 546. (3-30-07)

d. Optometrist services are described in Sections 550 through 556. (3-30-07)

05. Primary Care Case Management. Primary Care Case Management services are

described in Sections 560 through 56**6** of these rules**.** (3-30-07)

06. Prevention Services. The range of prevention services covered is described in Sections 570 through 646 of these rules. (3-30-07)

a. Health Risk Assessment services are described in Sections 570 through 576. (3-30-07)

b. Child wellness services are described in Sections 580 through 586. (3-30-07)

c. Adult physical services are described in Sections 590 through 596. (3-30-07)

d. Screening mammography services are described in Sections 600 through 606. (3-30-07)

e. Diagnostic Screening Clinic services are described in Sections 610 through 616. (3-30-07)

f. Personal Health Account services are described in Sections 620 through 626. (3-30-07)

g. Nutritional services are described in Sections 630 through 636. (3-30-07)

h. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 656 of these rules. (3-30-07)

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 666 of these rules. (3-30-07)

09. Family Planning. Family planning services are described in Sections 680 through 686 of these rules. (3-30-07)

10. Mental Health Services. The range of covered Mental Health services are described in Sections 700 through 716 of these rules. (3-30-07)

a. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-30-07)

b. Mental Health Clinic services are described in Sections 707 through 718. (3-30-07)

11. Home Health Services. Home health services are described in Sections 720 through 726 of these rules. (3-30-07)

12. ***~~Therapies~~*** **Therapy Services**. Occupational therapy, ~~P~~physical therapy, and

speech-language pathology 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.*~~
~~*(3-30-07)*~~(____)

13. ~~*Speech Language and Hearing*~~ **Audiology Services**. Audiology services are described in Sections 740 through 746 of these rules. ~~*(3-30-07)*~~(____)

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. (3-30-07)

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)

b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)

c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)

15. Vision Services. Vision services are described in Sections 780 through 786 of these rules. (3-30-07)

16. Dental Services. The range of covered dental and denturist services is described in Sections 800 through 806 of these rules. (3-30-07)

17. Essential Providers. The range of covered essential services is described in Sections 820 through 856 of these rules. (3-30-07)

a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)

b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)

c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)

d. School-Based services are described in Sections 850 through 856. (3-30-07)

18. Transportation. The range of covered transportation services is described in Sections 860 through 876 of these rules. (3-30-07)

a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)

b. Non-emergency transportation services are described in Sections 870 through 876. (3-30-07)

19. EPSDT Services. EPSDT services are described in Sections 880 through 886 of these rules. (3-30-07)

20. Specific Pregnancy-Related Services. Specific pregnancy-related services are described in Sections 890 through 896 of these rules. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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, and speech-language pathology services. ~~*(3-30-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

SUB AREA L: ~~THERAPIES~~ THERAPY SERVICES
(Sections 730 through 739)

730. ~~*PHYSICAL*~~ THERAPY SERVICES - DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Duplicate Services. Services are considered duplicate: ( )

a. When participants receive any combination of physical therapy, occupational therapy, or speech-language pathology services with treatments, evaluations, treatment plans, or goals that are not separate and unique to each service provided; or ( )

b. When more than one (1) type of therapy is provided at the same time. ( )

02. Maintenance Program. A maintenance program consists of any combination of drills, techniques, exercises, treatments, or activities that preserve the participant's present level of functioning and prevent regression of that function. A maintenance program begins when: ( )

a. The therapeutic goals of a treatment plan have been achieved and no further functional progress is expected to occur; ( )

b. The client or his caregivers, or both, have been taught and can carry out the therapy procedures; or ( )

c. The skills of a therapist are no longer required. ( )

03. **Occupational Therapy Services**. Therapy services that: ( )

a. Are provided within the scope of practice of licensed occupational therapists; ( )

b. Are necessary for the evaluation and treatment of impairments, functional disabilities, or changes in physical function and health status; and ( )

c. Improve the individual's ability to perform those tasks required for independent functioning. ( )

04. **Physical Therapy Services**. Therapy services that: ( )

a. Are provided within the scope of practice of licensed physical therapists; ( )

b. Are necessary for the evaluation and treatment of physical impairment or injury by the use of therapeutic exercise and the application of modalities that are intended to restore optimal function or normal development; and ( )

c. Focus on the rehabilitation and prevention of neuromuscular, musculoskeletal, integumentary, and cardiopulmonary disabilities. ( )

05. **Speech-Language Pathology Services**. Therapy services that are: ( )

a. Provided within the scope of practice of licensed speech-language pathologists; and ( )

b. Necessary for the evaluation and treatment of speech and language disorders which result in communication disabilities; or ( )

c. Necessary for the evaluation and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. ( )

06. **Supervision**. ( )

a. Direct supervision requires that the therapist be physically present and available to render direction in person and on the premises where the therapy is being provided. ( )

b. General supervision requires direct, on-premises contact between the therapist, the therapy assistant, and the participant at least every five (5) visits or once every week if seen on a daily basis. Between direct contacts, the therapist is required to maintain indirect, off-premises contact with the therapy assistant. These indirect, off-premises contacts may be by telephone, written reports, or group conferences. ( )

07. **Therapeutic Procedures**. Therapeutic procedures are the application of clinical skills, services, or both, that attempt to improve function. ( )

08. **Therapist**. An individual licensed by the appropriate Idaho state licensing board as an occupational therapist, physical therapist, or speech-language pathologist. ( )

09. **Therapy Assistant**. An individual licensed by the appropriate therapy licensure board to assist in the practice of occupational or physical therapy under the supervision of the appropriate licensed therapist. The therapy assistant is not recognized as an independent Medicaid provider. ( )

10. **Therapy Services**. Occupational therapy, physical therapy, and speech-language pathology services are all considered to be therapy services. These services are ordered by the participant's attending physician, nurse practitioner, or physician assistant as part of a plan of care. ( )

~~0~~11. **Treatment Modalities**. ~~*Modalities are*~~ A treatment modality is any physical agent applied to produce therapeutic changes to biological tissue, including the application of thermal, acoustic, light, mechanical or electrical energy. ~~*(3-30-07)*~~( )

~~***02. Therapeutic Procedures**. Therapeutic procedures are the application of clinical skills, services, or both that attempt to improve function. (3-30-07)***

731. ~~***(RESERVED)***~~ **THERAPY SERVICES - PARTICIPANT ELIGIBILITY.**
To be eligible for therapy services, a participant must be eligible for Medicaid benefits and must have: ( )

01. **Physician Order**. A physician order for therapy services; ( )

02. **Referral**. A referral from their Healthy Connections Primary Care Provider when applicable; ( )

03. **A Therapy Evaluation Showing Need**. A therapy evaluation of the participant showing a need for therapy due to a functional limitation, a loss or delay of skill, or both; and ( )

04. **A Therapy Evaluation Establishing Participant Benefit**. A therapy evaluation establishing that the participant will benefit and demonstrate progress as a result of the therapy services. ( )

732. ~~***PHYSICAL***~~ **THERAPY SERVICES - COVERAGE AND LIMITATIONS.**
Therapy services are covered under these rules when provided by the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, developmental disability agencies, school-based services, independent practitioners, and home health agencies. ( )

01. **Service Description**: **Occupational Therapy and Physical Therapy**. ~~*The following*~~ ~~*m*~~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 (CPT Manual) are covered~~.~~ with the following limitations: ~~*(3-30-07)*~~( )

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.*~~ Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. ~~*(3-30-07)*~~( )

b. ~~*All therapeutic procedures*~~ Any CPT procedure code that falls under the heading of either, "Active Wound Care Management," or "Tests and Measurements," requires 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.*~~ ~~*(3-30-07)*~~( )

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 the CPT ~~*procedure codes 95831 through 95904*~~ Manual when ordered by a physician, nurse practitioner, or physician assistant. ~~*(3-30-07)*~~( )

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.*~~ Any assessment provided under the heading "Orthotic Management and Prosthetic Management" must be completed by the therapist. ~~*(3-30-07)*~~( )

e. Any modality that is defined as "unlisted" in the CPT Manual requires prior authorization by the Department. In this case, the therapist and the physician, nurse practitioner, or physician assistant must provide information in writing to the Department that documents the medical necessity of the modality requested. ( )

f. The services of therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service. Therapy assistants act at the direction and under the supervision of the treating therapist and in accordance with state licensure rules. ( )

02. Service ~~*Limited*~~ Description: Speech-Language Pathology. ~~*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.*~~ Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. ~~*(3-30-07)*~~( )

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. ( )

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement. ( )

b. Services that address developmentally acceptable error patterns. ( )

c. Services that do not require the skills of a therapist or therapy assistant. ( )

d. Services provided by unlicensed aides or technicians, even if under the supervision of a therapist, except as provided under Section 854 of these rules. ( )

e. Massage, work hardening, and conditioning. ( )

f. Services that are not medically necessary, as defined in Section 011 of these rules. ( )

g. Maintenance programs, as defined under Section 730 of these rules. ( )

h. Duplicate services, as defined under Section 730 of these rules. ( )

i. Group therapy in settings other than school-based services and developmental disability agencies. ( )

04. Service Limitations. ( )

a. Physical Therapy and Occupational Therapy. Each participant is limited to twenty-five (25) outpatient physical therapy visits and twenty-five (25) outpatient occupational therapy visits during any calendar year. The Department may prior authorize additional visits if additional physical therapy or occupational therapy services, or both, are determined to be medically necessary. ( )

b. Speech-Language Pathology Services. Each participant is limited to forty (40) outpatient speech-language pathology visits during any calendar year. The Department may prior authorize additional visits if additional speech-language pathology services are determined to be medically necessary. ( )

c. Exceptions to visit limitations. ( )

i. Therapy provided by home health agencies is subject to the limitations on home

health visits contained in Section 722 of these rules. ( )

ii. Therapy provided through school-based services is not included in the visit limitations under Subsection 732.04 of this rule. ( )

733. ~~PHYSICAL~~ THERAPY SERVICES - PROCEDURAL REQUIREMENTS.
The Department will pay for ~~physical~~ therapy services rendered by or under the supervision of a licensed ~~physical~~ therapist if such services are ordered by the attending physician, nurse practitioner, or physician assistant as part of a plan of care. ~~(3-30-07)~~( )

01. Physician Orders. ( )

a. All ~~physical~~ therapy must be ordered by a physician, nurse practitioner, or physician assistant. ~~and s~~Such orders must include at a minimum, the service to be provided, the frequency, and, where applicable, the duration of each therapeutic session. ( )

b. 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~~ with the following exceptions: ( )

i. ~~t~~Therapy provided by home health agencies must be included in the home health plan of care and be reordered ~~not less often than~~ at least every sixty (60) days. ( )

ii. Therapy for ~~I~~individuals with chronic medical conditions, as documented by physician, nurse practitioner, or physician assistant, ~~may~~ must be reordered ~~up to~~ at least 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.~~ ~~(3-30-07)~~( )

02. Level of Supervision. ( )

a. General supervision of therapy assistants is required when therapy services are provided by outpatient hospitals, nursing facilities, home health agencies, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, and providers of school-based services. ( )

b. Direct supervision of therapy assistants is required when therapy services are provided by independent practitioners. ( )

c. All therapy services provided in a developmental disabilities agency must be provided by the therapist in accordance with IDAPA 16.04.11, "Developmental Disabilities Agencies." ( )

734. ~~(RESERVED)~~ THERAPY SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
The following providers are qualified to provide therapy services as Medicaid providers. ( )

01. **Occupational Therapist, Licensed**. A person licensed by the State Board of Medicine to conduct occupational therapy assessment and therapy in accordance with the Occupational Therapy Practice Act, Title 54, Chapter 37, Idaho Code, and IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (____)

02. **Physical Therapist, Licensed**. A person licensed by the Physical Therapy Licensure Board to conduct physical therapy assessments and therapy in accordance with the Physical Therapy Practice Act, Title 54, Chapter 22, Idaho Code, and IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board." (____)

03. **Speech-Language Pathologist, Licensed**. A person licensed by the Speech and Hearing Services Licensure Board to conduct speech-language assessments and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, and IDAPA 24.23.01, "Rules of the Speech and Hearing Services Licensure Board," 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. (____)

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. ~~*(3-30-07)*~~(____)

02. Payment Procedures. Payment procedures are as follows: (3-30-07)

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. The physician recertification must be on the copy of the physician's order 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.*~~ Therapy provided by home health agencies will be paid at a per visit rate as described in Section 725 of these rules and in accordance with IDAPA 16.03.07, "Rules for Home Health Agencies." ~~*(3-30-07)*~~(____)

b. ~~*Physical t*~~Therapists identified by Medicare as independent practitioners and enrolled as Medicaid providers will be ~~*paid*~~ reimbursed on a fee-for-service basis. The maximum fee paid will be based upon the Department's fee schedule, available from the Medicaid Central Office, see Section 005 of these rules. Only these practitioners can bill the Department directly for their services. A therapy assistant cannot bill Medicaid directly. ~~*(3-30-07)*~~(____)

c. ~~*Physical t*~~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. ~~*(3-30-07)*~~(____)

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."
~~*(3-30-07)*~~(____)

e. Payment for therapy services rendered to participants in school-based services is described in Section 855 of these rules. (____)

736. THERAPY SERVICES - QUALITY ASSURANCE ACTIVITIES.

01. Unreimbursable Services and Penalties. Therapy services that are not medically necessary or that are not specifically covered by these rules are not reimbursable, and if paid are subject to recoupment and penalties under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." (____)

02. Therapist Conditions and Requirements. The therapist is required to formulate all therapy interventions in accordance with the applicable licensure rules in IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." or IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," or IDAPA 24.23.01, "Rules of the Speech and Hearing Services Licensure Board," as well as the applicable association's professional Code of Ethics and Standards supporting best practice. (____)

03. Documentation. (____)

a. 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. (____)

b. The following documentation must be maintained in the files of the provider:
(____)

i. Physician, nurse practitioner, or physician assistant orders for therapy services;
(____)

ii. Therapy plans of care; and (____)

iii. Progress or other notes documenting each assessment, each therapy session, and results of tests and measurements related to therapy services. (____)

c. The provider must grant the Department immediate access to all information required to review compliance with these rules, as required in Section 330 of these rules. The absence of such documentation is cause for recoupment of Medicaid payment. (____)

~~***736. 737. (RESERVED).***~~

~~***738. SPEECH AND OCCUPATIONAL THERAPY SERVICES.***~~
~~*Speech 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 outpatient hospitals, home health agencies, and school-based services*~~

~~*providers.*~~ ~~*(3-30-07)*~~

737. -- 739. (RESERVED).

SUB AREA M: ~~SPEECH LANGUAGE AND HEARING~~ AUDIOLOGY SERVICES
(Sections 740 through 749)

740. ~~*(RESERVED)*~~ AUDIOLOGY SERVICES.
Audiology services are diagnostic, screening, preventive, or corrective services provided by an audiologist. These services must be provided in accordance with Title 54, Chapter 29, Idaho Code, and require the order of a physician, nurse practitioner, or physician assistant. Audiology services do not include equipment needed by the patient such as communication devices or environmental controls. ( )

(BREAK IN CONTINUITY OF SECTIONS)

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. (3-30-07)

01. Medical Necessity Criteria. Department standards for medical necessity are those national standards set by Centers for Medicare and Medicaid Services (CMS) in the Medicare DME MAC Jurisdiction D Supplier 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 Medicare DME MAC Jurisdiction D Supplier 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: (3-30-07)

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 (3-30-07)

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 (3-30-07)

c. For medical equipment, a full description of the equipment needed. All modifications or attachments to basic equipment must be supported; and (3-30-07)

d. For medical supplies, the type and quantity of supplies necessary must be identified; and (3-30-07)

e. Documentation of the participant's medical necessity for the item, that meets coverage criteria in the CMS/Medicare DME coverage manual. (3-30-07)

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. (3-30-07)

g. Items for convenience, comfort or cosmetic reasons are not covered. (3-30-07)

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: (3-30-07)

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. (3-30-07)

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; (3-30-07)

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. (3-30-07)

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. (3-30-07)

c. Communication devices will be considered for purchase by the Department under the following conditions. (3-30-07)

i. The need for the device must be based on a comprehensive history and physical. (3-30-07)

ii. The individual must lack the ability to communicate needs with the primary care physician or caregiver. (3-30-07)

iii. If the individual knows sign language or is capable of learning sign language a communication device would not be considered medically necessary. (3-30-07)

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: (3-30-07)

(1) Demographic and biographic summary; (3-30-07)

(2) Inventory of skills and sensory function; (3-30-07)

(3) Inventory of present and anticipated future communication needs; (3-30-07)

(4) Summary of device options; (3-30-07)

(5) Recommendation for device; and (3-30-07)

(6) Copy of individual treatment plan. (3-30-07)

v. Repairs to the device must be prior authorized and must not include modifications, technological improvements or upgrades. (3-30-07)

vi. Reimbursable supplies include rechargeable batteries, overlays, and symbols. (3-30-07)

vii. The use or provision of the system by any individual other than the participant for which the system was authorized is prohibited (3-30-07)

viii. Training and orientation in the use of the communication device may be billed as ~~*speech therapy*~~ speech-language pathology services by Medicaid~~-*approved*~~ providers ~~*such as a Developmental Disability Agency, or a Hospital that employs a speech therapist*~~ of speech-language pathology services. ~~*(3-30-07)*~~( )

d. Maternity abdominal supports will be covered if the participant has: (3-30-07)

i. Vulvular varicosities; (3-30-07)

ii. Perineal edema; (3-30-07)

iii. Lymphedema; (3-30-07)

iv. External prolapse of the uterus or bladder; (3-30-07)

v. Hip separation; (3-30-07)

vi. Pubic symphysis separation; or (3-30-07)

vii. Severe abdominal or back strain. (3-30-07)

e. Apnea monitor~~s~~ when there is one (1) or more documented apneic episodes in the ~~*last*~~ previous two (2) months. ~~*(3-30-07)*~~( )

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. (3-30-07)

a. Each request for prior authorization must include all information required in Subsection 752.01 of this rule. (3-30-07)

b. Supplies other than those listed below will require prior authorization: (3-30-07)

i. Catheter supplies including catheters, drainage tubes, collection bags, and other incidental supplies; (3-30-07)

ii. Cervical collars; (3-30-07)

iii. Colostomy and/or urostomy supplies; (3-30-07)

iv. Cotton tip applicators; (3-30-07)

v. Disposable supplies necessary to operate Department-approved medical equipment such as suction catheters, syringes, saline solution, etc.; (3-30-07)

vi. Dressings and bandages to treat wounds, burns, or provide support to a body part; (3-30-07)

vii. Fluids for irrigation; (3-30-07)

viii. Incontinence supplies (See Subsection 752.04.b. of this rule for limitations); (3-30-07)

ix. Injectable supplies including normal saline and Heparin but excluding all other prescription drug items; (3-30-07)

x. Blood glucose or urine glucose checking/monitoring materials (tablets, tapes, strips, etc.), lancets; and (3-30-07)

xi. Therapeutic drug level home monitoring kits. (3-30-07)

xii. Oral, enteral, or parenteral nutritional products, see Subsection 752.04.a. of this rule additional documentation requirements. (3-30-07)

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: (3-30-07)

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. (3-30-07)

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; (3-30-07)

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; (3-30-07)

iii. Documentation of evaluation and updating of the nutritional plan and assessment by a physician as needed but at least annually. (3-30-07)

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: (3-30-07)

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. (3-30-07)

ii. Disposable underpads are restricted to one hundred fifty (150) per month. (3-30-07)

iii. Pullups, for participants between the ages of four (4) and twenty-one (21), 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. ~~(3-30-07)~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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), 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; Senate Bill No. 1339 (2006); and State Plan Amendment 06-005.

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 July 4, 2007, Idaho Administrative Bulletin, Vol. 07-7, pages 47 through 61.

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, contact Jeanne Siroky at (208) 364-1897.

DATED this 23rd day of August, 2007.

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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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0310-0701***
Medicaid Enhanced Plan Benefits ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221, Idaho Code, notice is hereby given this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, and 56-1004A, Idaho Code, and Title XIX and Title XXI of the Social Security Act, as amended, and the companion federal regulations; Senate Bill No. 1339 (2006); and State Plan Amendment 06-005.

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

Tuesday, July 17, 2007
2:00 p.m.
Division of Medicaid
Conference Room "D" East
3232 Elder 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 a nontechnical explanation of the substance and purpose of the proposed rulemaking:

IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks," previously contained general language requiring criminal history background checks for providers of Medicaid services who provide direct care or services to children or vulnerable adults. Effective January 1, 2007, this general language was removed and references were added to specific Department program rules to assure that all providers who provide HCBS services to vulnerable adults are required to complete a criminal history background check.

Another change is being made. Senate Bill No. 1339, passed during the 2006 Legislative session, removed the requirement for a physician's order for Personal Care Services. An amendment to Idaho's state plan removing this requirement was recently approved by the Centers for Medicare and Medicaid Services. This rule change implements the law and state plan changes.

This rulemaking was published as a temporary rule in the February 7, 2007, Idaho Administrative Bulletin, Vol. 07-2, pages 30 through 44.

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 text changes are required to be in compliance with Section 56-1004A, Idaho Code.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary rule, contact Jeanne Siroky, Division of Medicaid at (208) 364-1897.

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, July 25, 2007.

DATED this 3rd day of May, 2007.

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2007.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted 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; Senate Bill No. 1339 (2006); and State Plan Amendment 06-005.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks," currently contains general language requiring criminal history background checks for providers of Medicaid services who provide direct care or services to children or vulnerable adults. Effective January 1, 2007, this general language will be removed and references will be added to specific Department program rules to assure that all providers who provide Home and Community Based Services to vulnerable adults are required to complete a criminal history background check.

Another change is being made. Senate Bill No. 1339, passed during the 2006 Legislative session, removed the requirement for a physician's order for Personal Care Services. An amendment to Idaho's state plan removing this requirement was recently approved by the Centers for Medicare and Medicaid Services. This rule change implements the law and state plan changes.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)a and b, Idaho

Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

For the protection of public health, safety, and welfare and to comply with state law. This rulemaking is initiated to comply with the provisions of Senate Bill No. 1339, passed by the 2006 Legislature and amendments to the Idaho Medicaid State Plan.

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

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact LaDonna Larson, Division of Medicaid at (208) 287-1162.

DATED this 5th day of January, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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 have complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." (3-19-07)

02. Availability to Work or Provide Service. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

04. Providers Subject to Criminal History and Background Check Requirements. The following providers are required to have a criminal history and background check: (3-19-07)

a. Adult Day Care Providers. The criminal history and background check requirements applicable to providers of adult day care as provided in Sections 329 and 705 of these rules. ~~(3-19-07)~~( )

b. Adult Residential Care Providers. The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules. ( )

c. Attendant Care Providers. The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules. ( )

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Sections 329 and 705 of these rules. ( )

~~**b**~~**e.** 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 S~~*ubs*~~ections 305, 329 and 705~~*.01*~~ of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." ~~(3-19-07)~~( )

f. Chore Services Providers. The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules. ( )

g. Companion Services Providers. The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules. ( )

h. Day Rehabilitation Providers. The criminal history and background check requirements applicable to day rehabilitation providers as provided in Section 329 of these rules. ( )

~~**c**~~**i.** 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 009. (3-19-07)

j. Homemaker Services Providers. The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules. ( )

~~**d**~~**k.** 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. (3-19-07)

~~e~~l. 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. (3-19-07)

~~f~~m. Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. (3-19-07)

n. Psychiatric Consultation Providers. The criminal history and background check requirements applicable to psychiatric consultation providers as provided in Section 329 of these rules. ( )

~~g~~o. 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. (3-19-07)

~~h~~p. Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 329 and 705 of these rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301. ~~(3-19-07)~~( )

q. Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329 and 705 of these rules. ( )

~~i~~r. 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. (3-19-07)

s. Supported Employment Providers. The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules. ( )

(BREAK IN CONTINUITY OF SECTIONS)

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)." (3-19-07)

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: (3-19-07)

a. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS. (3-19-07)

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; (3-19-07)

c. The RMS reviews the documentation for medical necessity; and ~~*(3-19-07)*~~(____)

d. The participant has a plan of care~~;~~. ~~*and*~~ ~~*(3-19-07)*~~(____)

~~**e.** *Services are ordered by a physician or authorized provider.* *(3-19-07)*~~

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. (3-19-07)

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.(3-19-07)

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*~~. ~~*(3-19-07)*~~(____)

b. The medical redetermination must assess the following factors: (3-19-07)

i. The participant's continued need for PCS; (3-19-07)

ii. Discharge from PCS; and (3-19-07)

iii. Referral of the participant from PCS to a nursing facility. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

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. (3-19-07)

a. The plan of care for participants who live in their own homes is based on: (3-19-07)

i. The physician's or authorized provider's information if applicable; ~~(3-19-07)~~( )

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 (3-19-07)

iii. Information obtained from the participant. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

a. Oversight must include all of the following: (3-19-07)

i. Assistance in the development of the written plan of care; (3-19-07)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-19-07)

iii. Reevaluation of the plan of care as necessary; and (3-19-07)

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. (3-19-07)

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: (3-19-07)

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; (3-19-07)

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; (3-19-07)

iii. Reevaluation of the plan of care as necessary, but at least annually; and (3-19-07)

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. (3-19-07)

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. (3-19-07)

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: (3-19-07)

i. Date and time of visit; (3-19-07)

ii. Length of visit; (3-19-07)

iii. Services provided during the visit; and (3-19-07)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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.” (3-19-07)

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.” (3-19-07)

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. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

329. AGED OR DISABLED WAIVER SERVICES - PROVIDER QUALIFICATIONS AND DUTIES.
Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary 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. (3-30-07)

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: (3-19-07)

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

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

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

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

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

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

g. To offer a full range of services and perform all services contained in a written agreement between the participant and the provider; (3-19-07)

h. Make referrals for PCS eligible participant for service coordination when a need for such services is identified; and (3-19-07)

i. Obtain such criminal background checks and health screens on new and existing

employees of record and fact as required. (3-19-07)

03. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. (3-19-07)

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (3-19-07)

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

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

i. Companion services; ( )

ii. Chore services; and ( )

iii. Respite care services. ( )

04. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (3-19-07)

05. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (3-19-07)

06. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (3-19-07)

a. A master's degree in a behavioral science; (3-19-07)

b. Be licensed in accordance with state law and regulations; or (3-19-07)

c. ~~*Have a*~~ 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. ~~*(3-19-07)*~~( )

d. Psychiatric consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ( )

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. (3-19-07)

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. (3-19-07)

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. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." ~~*(3-19-07)*~~( )

10. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (3-19-07)

a. Supervising the direct service; (3-19-07)

b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (3-19-07)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (3-19-07)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (3-19-07)

e. Being inspected and licensed as a food establishment by the district health department. (3-19-07)

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. (3-19-07)

12. Adult Day Care. Facilities that provide adult day care must be maintained in safe and sanitary manner. (3-30-07)

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (3-19-07)

b. Providers who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. (3-30-07)

c. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ( )

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. (3-19-07)

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

15. Attendant Care. See Subsection 329.03 of this rule for provider qualifications. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ~~(3-19-07)~~( )

16. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ~~(3-19-07)~~( )

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. (3-19-07)

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: (3-30-07)

a. Direct service staff must meet the following minimum qualifications: (3-30-07)

i. Be at least eighteen (18) years of age; (3-30-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of care; (3-30-07)

iii. Have current CPR and First Aid certifications; (3-30-07)

iv. Be free from communicable diseases; (3-30-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho

Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)

vi. Residential habilitation providers who provide direct care or services must ~~S~~satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks;" ~~(3-30-07)~~( )

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.18.c. of this rule. (3-30-07)

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services 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. (3-30-07)

d. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-30-07)

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

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

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

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

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

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

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

viii. Working with individuals with traumatic brain injuries; and (3-19-07)

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

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: (3-30-07)

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

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

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

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

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

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

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

f. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed; and (3-30-07)

g. When residential habilitation services are provided in the provider's home, the provider must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider agreement or contract. (3-30-07)

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. Day rehabilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-30-07)~~( )

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. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-30-07)~~( )

21. Behavior Consultation or Crisis Management Service Providers. Behavior consultation or crisis management providers must meet the following: (3-30-07)

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (3-30-07)

b. Be a licensed pharmacist; or (3-30-07)

c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-30-07)

d. Take a traumatic brain injury training course approved by the Department. (3-30-07)

e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (3-30-07)

f. Behavior consultation or crisis management service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ( )

(BREAK IN CONTINUITY OF SECTIONS)

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. (3-19-07)

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: (3-19-07)

a. Direct service staff must meet the following minimum qualifications: (3-19-07)

i. Be at least eighteen (18) years of age; (3-19-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to an plan of service; (3-19-07)

iii. Have current CPR and First Aid certifications; (3-19-07)

iv. Be free from communicable diseases; (3-19-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007. (3-19-07)

vi. Residential habilitation service providers who provide direct care or services must ~~S~~satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ~~(3-19-07)~~(____)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-19-07)

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. (3-19-07)

c. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-19-07)

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

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

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

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

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

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

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

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

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

d. Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: (3-19-07)

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

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

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

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

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

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

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

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

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. (3-19-07)

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

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

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

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ( )

03. Respite. Providers of respite care services must meet the following minimum qualifications: (3-19-07)

a. Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (3-19-07)

b. Have received care giving instructions in the needs of the person who will be

provided the service; (3-19-07)

c. Demonstrate the ability to provide services according to an plan of service; (3-19-07)

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-19-07)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (3-19-07)

f. Be free of communicable diseases. (3-19-07)

g. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ( )

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. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ~~(3-19-07)~~( )

05. Transportation. Providers of transportation services must: (3-19-07)

a. Possess a valid driver's license; and (3-19-07)

b. Possess valid vehicle insurance. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations services must: (3-19-07)

a. Be done under a permit, if required; and (3-19-07)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (3-19-07)

07. Specialized Equipment and Supplies. Specialized Equipment and Supplies purchased under this service must: (3-19-07)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (3-19-07)

b. Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the

design of the equipment. (3-19-07)

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. (3-19-07)

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: (3-19-07)

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; (3-19-07)

b. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (3-19-07)

c. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (3-19-07)

d. Provide documentation of current driver's license for each driver; and (3-19-07)

e. Must be inspected and licensed as a food establishment by the District Health Department. (3-19-07)

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. (3-19-07)

11. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-19-07)

b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (3-19-07)

c. Be a licensed pharmacist; or (3-19-07)

d. Be a Qualified Mental Retardation Professional (QMRP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, “Rules Governing Residential Habilitation Agencies.” (3-19-07)

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." ( )

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: (3-19-07)

a. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (3-19-07)

b. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (3-19-07)

c. Be free from communicable disease; (3-19-07)

d. Adult day care providers who provide direct care or services must ~~S~~satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"; ~~(3-19-07)~~( )

e. Demonstrate knowledge of infection control methods; and (3-19-07)

f. Agree to practice confidentiality in handling situations that involve waiver participants. (3-19-07)

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

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0702

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending and is also adopting this rule as 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 the required finding and concise statement of its supporting reasons for adopting a temporary rule and a concise explanatory statement of the reasons for adopting the pending rule.

These rules were amended in response to 2007 legislation which rejected certain subsections of rules relating to eligibility criteria for mental health services for children and adults. This rule change establishes the eligibility criteria for the Enhanced Plan mental health services to facilitate the appropriate placement of qualified participants with services that match their health needs.

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule was published in the April 4, 2007, Idaho Administrative Bulletin, Vol. 07-4, pages 15 through 18. The pending rule is being adopted as proposed. The original text of the proposed rule was published in the June 7, 2007, Idaho Administrative Bulletin, Vol. 07-6, pages 69 through 73.

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.

This rulemaking has no anticipated fiscal impact as this rule conforms the eligibility criteria with the 2006 House Concurrent Resolution 48. Current budget appropriations for these services were based on this legislation.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending rule or temporary rule, contact Pat Guidry, (208) 364-1813.

DATED this 26th day of July, 2007.

THE FOLLOWING NOTICE 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. The action is authorized pursuant to Sections 56-202(b), and 56-250 through 56-257, 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 June 20, 2007.

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 rules are being amended in response to 2007 legislation which rejected certain subsections of rules relating to eligibility criteria for mental health services for children and adults. This rule change establishes eligibility criteria for the Enhanced Plan mental health services to facilitate the appropriate placement of qualified participants with services that match their health needs. The following rule changes are being made:

1. **To be eligible to receive Enhanced Plan mental health services for psychotherapy, adults must meet the eligibility criteria of "serious mental illness," as defined in federal regulations.**

2. **Children must meet the eligibility criteria of "serious emotional disturbance," as defined in Section 16-2403, Idaho Code.**

3. **When determining whether an individual meets the diagnostic and functional eligibility criteria for Enhanced Plan mental health services for psychotherapy, the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-R) will be used for both children and adults along with a comprehensive assessment.**

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

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

There is no anticipated fiscal impact as this rule conforms the eligibility criteria with the

2006 House Concurrent Resolution 48. Current budget appropriations for these services were based on this legislation.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted. The negotiations were at the request of the 2007 Legislature, and no Notice of Negotiated Rulemaking was published in the Idaho Administrative Bulletin. On February 8, 2007, representatives from the Idaho Mental Health Providers Association and the Department met for negotiations.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Pat Guidry, (208) 364-1813.

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 June 27, 2007.

DATED this 27th day of April, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

112. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - PARTICIPANT ELIGIBILITY.
~~*In order t*~~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*~~ include documentation of the medical necessity for each service to be provided. For partial care services, the comprehensive assessment must also contain documentation that shows the participant is currently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration that would interfere with the participant's ability to maintain his current level of functioning. ~~*(3-21-07)*~~( )

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: (3-21-07)

a. Other services have failed or are not appropriate for the clinical needs of the participant. (3-21-07)

b. ~~*For each participant, t*~~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. ~~*(3-21-07)*~~( )

c. Participants identified in ~~*the list below are disqualified from participating*~~

Subsections 112.01.c.i. through 112.01.c.iii. of this rule cannot participate in Enhanced Outpatient Mental Health services: ~~(3-21-07)~~(____)

i. ~~*Persons*~~ Participants at immediate risk of self-harm or harm to others who cannot be stabilized; ~~(3-21-07)~~(____)

ii. ~~*Persons*~~ Participants needing more restrictive care or inpatient care; and ~~(3-21-07)~~(____)

iii. ~~*Persons*~~ Participants who have not fulfilled the requirements of Subsections 112.02 or 112.03 of these rules. ~~(3-21-07)~~(____)

02. Eligibility Criteria for Children. ~~*Individuals*~~ To be eligible for services, a participant under the age of eighteen (18) ~~*who*~~ must 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. ~~(3-21-07)~~(____)

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 ~~(3-21-07)~~(____)

b. Requires sustained treatment interventions; and (3-21-07)

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. (3-21-07)

d. 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. (3-21-07)

03. Eligibility Criteria for Adults. ~~*Individuals*~~ To be eligible for services, a participant must be eighteen (18) years or older ~~*who*~~ and have a ~~*severe and persistent*~~ serious mental illness (SM~~*P*~~I) as defined in Volume 58 of the Federal Register, 29422-02, June 24, 1999. ~~*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."*~~ ~~(3-21-07)~~(____)

~~***a.*** *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:* (3-21-07)~~

~~*i. Vocational/educational;* (3-21-07)~~

~~*ii. Financial;* (3-21-07)~~

~~*iii. Social relationships/support;* (3-21-07)~~

~~*iv. Family;* (3-21-07)~~

~~*v. Basic living skills;* (3-21-07)~~

~~*vi. Housing;* (3-21-07)~~

~~*vii. Community/legal; or* (3-21-07)~~

~~*viii. Health/medical.* (3-21-07)~~

a. Currently or at any time during the year, he must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR; and ( )

b. He must have a functional impairment which substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. ( )

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.*~~ **Level of Care Criteria - Mental Health Clinics**. To be eligible for mental health clinic services, a participant must meet the criteria as described in Subsections 112.04.a. and 112.04.b. of this rule. ~~*(3-21-07)*~~( )

a. Children must meet Subsections 112.01 and 112.02 of this rule. ( )

b. Adults must meet Subsections 112.01 and 112.03 of this rule. ( )

05. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Agencies and Partial Care Services for Children. To be eligible for the services of PSR or Partial Care, a child must meet the criteria of SED and Subsection 112.04.a. of this rule and must experience a 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 with moderate impairment in at least one (1) of the following three (3) scales in Subsections 112.05.a. through 112.05.c. of this rule. ( )

a. Self-harmful behavior; ( )

b. Moods/Emotions; or ( )

c. Thinking. ( )

06. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Agencies and

Partial Care Services for Adults. To be eligible for services of PSR or Partial Care, an adult must meet the criteria of SMI and Subsection 112.04.b. of this rule. In addition, the following criteria in Subsections 112.06.a. and 112.06.b. of this rule must be met. ( )

a. The participant must have a diagnosis under DSM-IV-TR, of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis; and ( )

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 in Subsection 112.05.b.i. through 112.05.b.viii. of this rule on either a continuous or an intermittent, at least once per year, basis: ( )

i. Vocational/educational; ( )

ii. Financial; ( )

iii. Social relationships/support; ( )

iv. Family; ( )

v. Basic living skills; ( )

vi. Housing; ( )

vii. Community/legal; or ( )

viii. Health/medical. ( )

0~~5~~7. Criteria Following Discharge For Psychiatric Hospitalization. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules are eligible for enhanced outpatient mental health clinic and PSR services. (3-21-07)

a. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsection 112.02 of ~~*these*~~ this rule~~s~~ for children, and in Subsection 112.03 of ~~*these*~~ this rule~~s~~ 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. ~~*(3-21-07)*~~( )

i. Up to two (2) hours of plan development hours may be for coordinating with hospital staff and others the participant chooses. These plan development hours are to be used for the development of an individualized treatment plan based 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. (3-21-07)

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. (3-21-07)

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*~~ The assessment must establish~~*ed*~~ that the participant meets the criteria ~~*for Serious Emotional Disturbance (SED) or Severe and Persistent Mental Illness (SPMI)*~~ as described in Subsections 112.01 through 112.06 of this rule, and is appropriate for the participant's age and level of care that is medically necessary. The mental health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced Plan. ~~*(3-21-07)*~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0703

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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), 56-203(i), 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 Wednesday, August 1, 2007, Idaho Administrative Bulletin, Vol. 07-8, pages 102 through 110. The companion rule for this docket published simultaneously under Docket No. 16-0323-0701.

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.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Susan Scheuerer at (208) 287-1156.

DATED this 20th day of September, 2007.

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@dhw.idaho.gov e-mail

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 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 rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), and 56-250 through 56-257, 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, August 15, 2007.

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

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

The current process used to determine a Medicaid participant's eligibility for nursing facility care results in delays for nursing facilities and participants. In the current process, after conducting a standard functional assessment on a participant, a nursing facility submits that person's assessment data in the form of the Minimum Data Set (MDS) to the Department. Department nurses then convert this data to a standardized score using the Department's Uniform Assessment Instrument (UAI). This score is used to determine if a participant needs the level of care provided by a nursing facility.

Rule changes are needed to eliminate this extra "conversion" step so that a participant's assessment data can be used directly to determine his eligibility for nursing facility care. This will make the process simpler and more efficient, use less staff time, and result in more rapid eligibility determination while maintaining the same degree of accuracy.

The rules that require UAI scoring be used to determine whether or not a participant needs nursing facility level of care are being moved from the Nursing Facility section of the rules to the Aged or Disabled (A&D) Waiver section.

This rule change will allow Medicaid to accept the MDS scores submitted by nursing facilities as sufficient to determine that a participant needs nursing facility level of care. Medicaid will no longer convert MDS scores to UAI scores. This way, MDS scores will be used directly to determine medical eligibility for nursing facility care. UAI scoring will still be used to determine eligibility for long-term care services covered under the A&D Waiver since the assessment process used to produce the MDS is only applicable to the nursing facility setting.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers a benefit.

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 is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes are being made to make the eligibility process easier for nursing facilities and more efficient for the Department. Informal discussions were held with the Idaho Health Care Association, the proposed changes were welcomed.

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

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 22, 2007.

DATED this 1st day of June, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

013. DEFINITIONS P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

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. (3-19-07)

02. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

03. Patient. The person undergoing treatment or receiving services from a provider. (3-19-07)

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. (3-19-07)

05. Personal Assistance Services (PAS). Services that include attendant care and personal care services. (3-19-07)

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. (3-19-07)

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." (3-19-07)

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. (3-19-07)

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. (3-19-07)

10. Private Rate. Rate most frequently charged to private patients for a service or item. (3-19-07)

11. PRM. The Provider Reimbursement Manual. (3-19-07)

12. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-19-07)

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. (3-19-07)

14. Property Rental Rate. A rate paid per Medicaid patient day to 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. (3-19-07)

15. 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 has entered into a written provider

agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

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. (3-19-07)

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. (3-19-07)

18. 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." (3-19-07)

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. (3-19-07)

20. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

21. 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. (3-19-07)

22. 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. (3-19-07)

23. 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.). (3-19-07)

24. Regional Medicaid Services (RMS). Regional offices of the Division of Medicaid. (3-19-07)

25. 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. (3-19-07)

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." (3-19-07)

27. 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 (3-19-07)

28. 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. (3-19-07)

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. (3-19-07)

30. 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 and determining nursing facility level of care. ~~(3-19-07)~~( )

31. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)

32. 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. (3-19-07)

33. 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. (3-19-07)

34. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-19-07)

35. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)

36. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)

37. 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. (3-19-07)

38. 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. (3-19-07)

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. (3-19-07)

40. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

41. Uniform Assessment. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

42. 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." (3-19-07)

43. Utilities. All expenses for heat, electricity, water and sewer. (3-19-07)

44. 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. (3-19-07)

45. 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. (3-19-07)

46. Vocational Services. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

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)*~~ Department 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. ~~*(3-19-07)*~~(____)

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. (3-19-07)

a. The participant can select any certified facility to provide the care required. (3-19-07)

b. The final decision as to the level of care required by a medical assistance participant must be made by the IOC/UC Nurse. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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,*~~ one (1) of the Resource Utilization Group (RUG III) classifications or when a child meets one (1) or more of the criteria described in Subsections 223.0~~7~~2, 223.0~~8~~3, 223.0~~9~~4 or 223.~~1~~05 of ~~*these*~~ this rule~~*s*~~. A child is an individual from age zero (0) through eighteen (18) years; an adult is an individual more than eighteen (18) years of age. ~~*(3-19-07)*~~(____)

01. Required Assessment for Adults. A standard assessment will be ~~*administered*~~ approved by the Department ~~*to*~~ for all adults requesting services with requirements for nursing facility level of care. The Department will specify the instrument to be used. ~~*(3-19-07)*~~(____)

~~***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:*~~ ~~*(3-19-07)*~~

~~***03. Critical Indicator—12 Points Each****.*~~ ~~*(3-19-07)*~~

~~**a.** *Total assistance with preparing or eating meals.* (3-19-07)~~

~~**b.** *Total or extensive assistance in toileting.* (3-19-07)~~

~~**c.** *Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking.* (3-19-07)~~

~~**04. High Indicator - 6 Points Each.** (3-19-07)~~

~~**a.** *Extensive assistance with preparing or eating meals.* (3-19-07)~~

~~**b.** *Total or extensive assistance with routine medications.* (3-19-07)~~

~~**c.** *Total, extensive or moderate assistance with transferring.* (3-19-07)~~

~~**d.** *Total or extensive assistance with mobility.* (3-19-07)~~

~~**e.** *Total or extensive assistance with personal hygiene.* (3-19-07)~~

~~**f.** *Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI).* (3-19-07)~~

~~**05. Medium Indicator - 3 Points Each.** (3-19-07)~~

~~**a.** *Moderate assistance with personal hygiene.* (3-19-07)~~

~~**b.** *Moderate assistance with preparing or eating meals.* (3-19-07)~~

~~**c.** *Moderate assistance with mobility.* (3-19-07)~~

~~**d.** *Moderate assistance with medications.* (3-19-07)~~

~~**e.** *Moderate assistance with toileting.* (3-19-07)~~

~~**f.** *Total, extensive, or moderate assistance with dressing.* (3-19-07)~~

~~**g.** *Total, extensive or moderate assistance with bathing.* (3-19-07)~~

~~**h.** *Extensive or moderate assistance with supervision from Section II No. 18 of the UAI.* (3-19-07)~~

~~**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.* (3-19-07)~~

~~**a.** *One (1) or more critical indicators = Twelve (12) points.* (3-19-07)~~

~~**b.** *Two (2) or more high indicators = Twelve (12) points.* (3-19-07)~~

~~***c.*** *One (1) high and two (2) medium indicators = Twelve (12) points.* *(3-19-07)*~~

~~***d.*** *Four (4) or more medium indicators = Twelve (12) points.* *(3-19-07)*~~

0~~7~~2. 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. (3-19-07)

0~~8~~3. 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. (3-19-07)

0~~9~~4. 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. (3-19-07)

~~1~~05. Nursing Facility Level of Care for Children. Using the criteria found in Subsections 223.0~~7~~2, 223.0~~8~~3, and 223.0~~9~~4 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. ~~*(3-19-07)*~~(____)

~~11~~06. Conditions of Payment. (3-19-07)

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. (3-19-07)

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. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

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)*~~ Department. 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. ~~*(3-19-07)*~~(____)

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. (3-19-07)

02. Information Required for Level I and II Screen Determination. An accurate Level I screen and when required, a Level II screen. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

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: (3-19-07)

01. Has a Disabling Condition. Requires services due to a disabling condition which impairs their mental or physical function or independence; and (3-19-07)

02. Safe in a Non-Institutional Setting. Be capable of being maintained safely and effectively in a non-institutional setting; and (3-19-07)

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*~~. ~~*(3-19-07)*~~(____)

04. 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 322.04 through 322.07 of this rule, according to the formula described in Subsection 322.08 of this rule. (____)

05. Critical Indicator - 12 Points Each. (____)

a. Total assistance with preparing or eating meals. (____)

b. Total or extensive assistance in toileting. (____)

c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking. (____)

06. High Indicator - 6 Points Each. (____)

a. Extensive assistance with preparing or eating meals. ( )

b. Total or extensive assistance with routine medications. ( )

c. Total, extensive or moderate assistance with transferring. ( )

d. Total or extensive assistance with mobility. ( )

e. Total or extensive assistance with personal hygiene. ( )

f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). ( )

07. Medium Indicator - 3 Points Each. ( )

a. Moderate assistance with personal hygiene. ( )

b. Moderate assistance with preparing or eating meals. ( )

c. Moderate assistance with mobility. ( )

d. Moderate assistance with medications. ( )

e. Moderate assistance with toileting. ( )

f. Total, extensive, or moderate assistance with dressing. ( )

g. Total, extensive or moderate assistance with bathing. ( )

h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. ( )

08. 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. ( )

a. One (1) or more critical indicators = Twelve (12) points. ( )

b. Two (2) or more high indicators = Twelve (12) points. ( )

c. One (1) high and two (2) medium indicators = Twelve (12) points. ( )

d. Four (4) or more medium indicators = Twelve (12) points. ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0704

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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), 56-203(i), 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 Department has reviewed and given due consideration to the public comments submitted for this rule. The comments expressed several concerns including new requirements for prior authorization of speech therapy and occupational therapy, a plan for reviewing the requests for prior authorization, the potential for increased cost to the state, as well as the increased potential for fraud and abuse.

The Department worked closely with the Idaho Occupational Therapy Association and the Idaho Speech and Hearing Association to develop rules that will increase access and ensure that participants will receive the right care at the right time, and, at the same time, prevent over-utilization of therapy services. The Department has conducted research on expected utilization, and there are processes in place to achieve the added responsibilities in a timely manner and to monitor for over-utilization. The Department is not requesting any changes to the proposed rule.

The pending rule is being adopted as proposed. The complete text of the proposed rule was published in the Wednesday, October 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 453 through 466.

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 to the state general fund related to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jeanne Siroky at (208) 364-1897.

DATED this 5th day of November, 2007.

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@dhw.idaho.gov e-mail

THE FOLLOWING NOTICE 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), 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.

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

Tuesday, October 16, 2007	**Wednesday, October 17, 2007**	**Tuesday, October 23, 2007**
6:00 p.m.	**6:00 p.m.**	**6:00 p.m.**
DHW - Region I Office	**DHW - Region IV Office**	**DHW - Human Development Ctr.**
1120 Ironwood Drive, Suite 102	**1720 Westgate Drive**	**421 Memorial Drive**
Coeur d'Alene, ID	**Suite D, Room 119, Boise, ID**	**Pocatello, 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 rulemaking aligns the content in this chapter related to speech-language pathology services and occupational therapy services with the changes being proposed concurrently under Docket No. 16-0309-0706.

These rule changes:

1. **Delete the limit of 250 speech therapy sessions per calendar year and add a citation to new text proposed for IDAPA 16.03.09 that establishes a new limit of 40 sessions per calendar year;**

2. **Add a citation to new text proposed for IDAPA 16.03.09 that establishes a new limit of 25 sessions per calendar year for occupational therapy sessions; and**

3. Make consistent the language used to refer to physical therapy, occupational therapy, and speech-language pathology services.

NOTE: For both of these therapy services, under new language being proposed concurrently in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," additional sessions may be prior authorized if they are determined to be medically necessary.

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 is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, informal negotiated rulemaking was conducted in the development of these rule changes. The groups involved in the informal negotiated rulemaking were: Idaho Occupational Therapy Association, Idaho Speech and Hearing Association, and the Idaho Physical Therapy Association.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jeanne Siroky at (208) 364-1897.

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 24, 2007.

DATED this 23rd day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

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. (3-19-07)

02. Individual Provider Payment. The Department will not pay the individual provider more than the lowest of: (3-19-07)

a. The provider's actual charge for service; or (3-19-07)

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 (3-19-07)

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. (3-19-07)

03. Payment for ~~*Speech, Occupational and Physical*~~ Therapy Services. The fees for physical therapy, occupational therapy, and speech~~ *therapy*~~-language pathology services 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. ~~*(3-19-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

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. (3-19-07)

01. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

02. Enhanced Mental Health Benefits. Enhanced Mental Health services are provided under Sections 100 through 147 of these rules. (3-19-07)

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. (3-19-07)

04. ~~*Therapies*~~ Therapy Services. Physical therapy, ~~*Speech, and O*~~occupational ~~*T*~~therapy, and speech-language pathology services are ~~*Providers*~~ provided as described in Section 215 of these rules. ~~*(3-19-07)*~~( )

05. Long Term Care Services. The following services are provided under the Long Term Care Services. (3-30-07)

a. Nursing Facility Services as described in Sections 220 through 299 of these rule
. (3-19-07)

b. Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)

c. A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)

06. Hospice. Hospice services as described in Sections 450 through 459 of these rules. (3-19-07)

07. Developmental Disabilities Services. (3-19-07)

a. Developmental Disability Standards as described in Sections 500 through 506 of these rules. (3-19-07)

b. Behavioral Health Prior Authorization as described in Sections 507 through 520 of these rules. (3-19-07)

c. ICF/MR as described in Sections 580 through 649 of these rules. (3-19-07)

d. Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules. (3-19-07)

08. Service Coordination Services. Service coordination as described in 720 through 779 of these rules. (3-19-07)

09. Breast and Cervical Cancer Program. Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

215. PHYSICAL THERAPY, ~~*SPEECH, AND*~~ OCCUPATIONAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY SERVICES.
In addition to the providers listed at IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 730 through 73~~8~~9, physical therapy, ~~*speech, and*~~ occupational therapy, and speech-language pathology services are covered under these rules when provided by a Developmental Disabilities Agencies. ~~*(3-19-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

326. AGED OR DISABLED WAIVER SERVICES - COVERAGE AND LIMITATIONS.

01. Adult Day Care. Adult day care is a supervised, structured day program, outside

the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (3-19-07)

02. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that includes: (3-19-07)

a. Medication management; (3-19-07)

b. Assistance with activities of daily living; (3-19-07)

c. Meals, including special diets; (3-19-07)

d. Housekeeping; (3-19-07)

e. Laundry; (3-19-07)

f. Transportation; (3-19-07)

g. Opportunities for socialization; (3-19-07)

h. Recreation; and (3-19-07)

i. Assistance with personal finances. (3-19-07)

j. Administrative oversight must be provided for all services provided or available in this setting. (3-19-07)

k. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (3-19-07)

03. Assistive Technology. Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. (3-19-07)

04. Assisted Transportation. Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (3-19-07)

a. Assisted transportation service is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 860 through 876, and will not replace it. (3-19-07)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (3-19-07)

05. Attendant Care. Attendant care services are those services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Services may occur in the participant's home, community, work, school or recreational settings. (3-30-07)

a. To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized. (3-19-07)

b. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (3-19-07)

06. Chore Services. Chore services include the services provided in Subsection 326.06.a. and 326.06.b. of this rule: (3-19-07)

a. Intermittent Assistance may include the following. (3-19-07)

i. Yard maintenance; (3-19-07)

ii. Minor home repair; (3-19-07)

iii. Heavy housework; (3-19-07)

iv. Sidewalk maintenance; and (3-19-07)

v. Trash removal to assist the participant to remain in their home. (3-19-07)

b. Chore activities may include the following: (3-19-07)

i. Washing windows; (3-19-07)

ii. Moving heavy furniture; (3-19-07)

iii. Shoveling snow to provide safe access inside and outside the home; (3-19-07)

iv. Chopping wood when wood is the participant's primary source of heat; and (3-19-07)

v. Tacking down loose rugs and flooring. (3-19-07)

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other

relative, caretaker, landlord, community volunteer, agency, or third party payer is willing to or is responsible for their provision. (3-19-07)

d. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

07. Adult Companion. In-home services to insure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (3-19-07)

08. Consultation. Consultation services are services to a participant or family member. Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self reliance possible for the participant/family. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (3-19-07)

09. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: (3-19-07)

a. Rent or own their own home; (3-19-07)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no regular caretaker for extended periods of time; and (3-19-07)

d. Are unable to prepare a balanced meal. (3-19-07)

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. (3-19-07)

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: (3-19-07)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (3-19-07)

b. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (3-19-07)

c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

12. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who: (3-19-07)

a. Rent or own their home, or live with unpaid relatives; (3-19-07)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no caretaker for extended periods of time; and (3-19-07)

d. Would otherwise require extensive routine supervision. (3-19-07)

13. Psychiatric Consultation. Psychiatric Consultation is direct consultation and clinical evaluation of participants, who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (3-19-07)

14. Respite Care. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (3-19-07)

15. 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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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: (3-19-07)

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (3-19-07)

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (3-19-07)

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (3-19-07)

d. Injections; (3-19-07)

e. Blood glucose monitoring; and (3-19-07)

f. Blood pressure monitoring. (3-19-07)

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. (3-30-07)

a. Residential habilitation services assist the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-30-07)

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-30-07)

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-30-07)

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; (3-30-07)

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (3-30-07)

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or (3-30-07)

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (3-30-07)

b. Day rehabilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day rehabilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech ~~*therapies*~~ language pathology services listed in the plan of care. In addition, day rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. ~~*(3-30-07)*~~( )

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. (3-30-07)

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained by RMS in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. (3-30-07)

b. Federal Financial Participation (FFP) 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. (3-30-07)

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. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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. (3-19-07)

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 Sections 729 through 732 of these rules. (3-19-07)

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 forty-five (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. (3-19-07)

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: (3-19-07)

a. Durable Medical Equipment (DME); (3-19-07)

b. Transportation; and (3-19-07)

c. Physical therapy, ~~*speech and*~~ occupational therapy, and speech-language pathology services provided outside of a Development Disabilities Agency (DDA). ~~*(3-19-07)*~~( )

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. (3-19-07)

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: (3-19-07)

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; (3-19-07)

b. Contact with service providers to identify barriers to service provision; (3-19-07)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)

d. Review of provider status reviews and complete a plan monitor summary after the six (6) month review and for annual plan development. (3-19-07)

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. (3-19-07)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 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: (3-19-07)

a. The status of supports and services to identify progress; (3-19-07)

b. Maintenance; or (3-19-07)

c. Delay or prevention of regression. (3-19-07)

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. (3-19-07)

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. (3-19-07)

09. Negotiation for the Plan of Service. The plan of service must be individualized with the participant if the requested services fall outside the 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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental modifications; (3-19-07)

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

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. (3-19-07)

iii. Convene the person-centered planning team to develop a new plan of service. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

15. Reconsiderations, Complaints, and Administrative Appeals. (3-19-07)

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. (3-19-07)

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. (3-19-07)

c. Administrative Appeals. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

653. DDA SERVICES - COVERAGE REQUIREMENTS AND LIMITATIONS.

01. Requirement for Plan of Service and Prior Authorization. (3-19-07)

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." (3-19-07)

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." (3-19-07)

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": (3-19-07)

a. Comprehensive Developmental Assessment; (3-19-07)

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; (3-19-07)

c. Occupational Therapy Assessment (3-19-07)

d. Physical Therapy Assessment; (3-19-07)

e. Speech and Language Assessment; (3-19-07)

f. Medical/Social History; and (3-19-07)

g. Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. (3-19-07)

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." (3-19-07)

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. (3-19-07)

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: (3-19-07)

i. Individual psychotherapy; (3-19-07)

ii. Group psychotherapy; and (3-19-07)

iii. Family-centered psychotherapy which must include the participant and one (1) other family member at any given time. (3-19-07)

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. (3-19-07)

d. Speech~~*-and Hearing Therapy*~~-Language Pathology Services. Speech~~*-and hearing therapy*~~-language pathology services ~~*are limited to two hundred fifty (250) treatment sessions per calendar year. Speech and hearing therapy*~~ include~~s~~ individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. ~~*(3-19-07)*~~( )

e. Physical Therapy Services. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 73~~7~~9. ~~*Physical therapy includes individual or group therapy.*~~ ~~*(3-19-07)*~~( )

f. Occupational Therapy Services. Occupational therapy services include~~s~~ individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. ~~*(3-19-07)*~~( )

g. Intensive Behavioral Intervention (IBI). IBI is limited to a lifetime limit of thirty six (36) months. (3-19-07)

i. The DDA must receive prior authorization from the Department prior to delivering IBI services. (3-19-07)

ii. IBI must only be delivered on an individualized, one-to-one basis. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

04. Excluded Services. The following services are excluded for Medicaid payments: (3-19-07)

a. Vocational services; (3-19-07)

b. Educational services; and (3-19-07)

c. Recreational services. (3-19-07)

05. Limitations on DDA Services. Therapy services may not exceed the limitations as specified below. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

HOUSE HEALTH AND WELFARE COMMITTEE

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.17 - MEDICARE/MEDICAID COORDINATED PLAN BENEFITS

DOCKET NO. 16-0317-0701 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendments to the temporary rule is April 1, 2007. This pending rule has been adopted by the agency and is now pending review by the 2008 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; Sections 56-251(2)(c) and 56-255(4), Idaho Code; the Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, Section 231; and HCR 49 (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:

A single addition is being made to the rule to clarify that both Medicare Advantage Plans and Medicaid are subject to applicable federal managed care requirements when administering the services under these rules. Under Section 67-5228, Idaho Code, typographical and clerical corrections have been made to the rule and are being published with this Notice of Rulemaking as part of the pending rule.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule. Only the sections that have changes from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the July 4, 2007, Idaho Administrative Bulletin, Vol. 07-7, pages 62 through 69. This docket was also published as a temporary rule in the April 4, 2007, Idaho Administrative Bulletin, Vol. 07-4, pages 19 through 25, with a temporary effective date of April 1, 2007. There were no differences in the text between the temporary and proposed rules.

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:

For SFY 2007, a total cost of $128,000 is estimated for changes to Medicaid's automated system to support implementation of the coordinated plan benefit package. The cost to the

State General Fund is estimated to be $12,800.

It is estimated that implementation of this benefit package will result in a savings of approximately $336,651 in SFY 2008, $743,501 in SFY 2009, and $1,231,526 in SFY 2010. No cost savings are anticipated for SFY 2007 because this benefit package will be implemented late in the fiscal year (April 2007).

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sheila Pugatch at (208) 364-1817.

DATED this 20th day of September, 2007.

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@dhw.idaho.gov e-mail

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221, Idaho Code, notice is hereby given this agency has adopted a proposed rule. The action is authorized pursuant to Section 56-202(b), Idaho Code; Sections 56-251(2)(c) and 56-255(4), Idaho Code; the Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, Section 231; and HCR 49 (2006).

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

Wednesday, July 18, 2007 **5:00 p.m.** **DHW - Region IV Office** **1720 Westgate Drive** **Suite D, Room 119** **Boise, ID**	**Wednesday, July 18, 2007** **7:00 p.m.** **Idaho Falls Public Library** **457 Broadway** **Idaho Falls, ID**	**Thursday, July 19, 2007** **7:00 p.m.** **DHW - Region I Office** **1120 Ironwood Drive, Suite 102** **Coeur d'Alene, ID**

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

DESCRIPTIVE SUMMARY: The following is 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:

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0317-0701***
Medicare/Medicaid Coordinated Plan Benefits ***PENDING RULE***

The 2006 Legislature directed the Department to increase its coordination with Medicare as part of the overall strategy for improving Medicaid efficiency and saving Medicaid funds. HCR 49 encouraged the Department to coordinate with Medicare in financing prescription drug benefits and other Medicaid-covered services for individuals eligible for and enrolled in both Medicare and Medicaid ("dually eligible").

This new chapter of rules implements the intent of HCR 49 and the corresponding benefit package approved by the Centers for Medicare/Medicaid Services (CMS) effective July 1, 2006, as part of Idaho's Medicaid Modernization plan. This benefit package coordinates and integrates benefits for individuals eligible for both Medicare and Medicaid. It is one of the three benefit packages that comprise Idaho's Medicaid Modernization plan. (The Basic and the Enhanced plans are the other two benefit packages.)

Individuals who opt into the Medicare/Medicaid Coordinated Plan will receive an integrated benefits program offered by a participating Medicare Advantage Organization (MAO). Medicaid will pay the premium for the integrated Medicare Advantage Plan* offered by a participating MAO. The integrated Medicare Advantage Plan will cover some services usually covered by Medicaid such as: primary care case management, prescribed drugs not covered by Medicare Part D, and dentures.

***Medicare Advantage Plans are health plans approved by Medicare but run by private companies referred to in this chapter as "MAOs."**

This docket was published as temporary rule in the April 4, 2007, Idaho Administrative Bulletin, Vol. 07-4, pages 19 through 25, with a temporary effective date of April 1, 2007.

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

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

For SFY 2007, a total cost of $128,000 is estimated for changes to Medicaid's automated system to support implementation of the coordinated plan benefit package. The cost to the State General Fund is estimated to be $12,800.

It is estimated that implementation of this benefit package will result in a savings of approximately $336,651 in SFY 2008, $743,501 in SFY 2009, and $1,231,526 in SFY 2010. No cost savings are anticipated for SFY 2007 because this benefit package will be implemented late in the fiscal year (April 2007).

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this new chapter of rule was written to implement: (1) legislation passed during the 2006 legislative session, and, (2) a benefit package approved by CMS as part of Idaho's Medicaid Modernization plan.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Sheila Pugatch at (208) 364-1817.

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, July 25, 2007.

DATED this 3rd day of May, 2007.

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 1, 2007.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Section 56-202(b), Idaho Code; Sections 56-251(2)(c) and 56-255(4), Idaho Code; the Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, Section 231; and HCR 49 (2006).

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

The 2006 Legislature directed the Department to increase its coordination with Medicare as part of the overall strategy for improving Medicaid efficiency and saving Medicaid funds. HCR 49 encouraged the Department to coordinate with Medicare in financing prescription drug benefits and other Medicaid-covered services for individuals eligible for and enrolled in both Medicare and Medicaid ("dually eligible").

This new chapter of rules implements the intent of HCR 49 and the corresponding benefit package approved by the Centers for Medicare/Medicaid Services (CMS) effective July 1, 2006, as part of Idaho's Medicaid Modernization plan. This benefit package coordinates and integrates benefits for individuals eligible for both Medicare and Medicaid. It is one of the three benefit packages that comprise Idaho's Medicaid Modernization plan. (The Basic and the Enhanced plans are the other two benefit packages.)

Individuals who opt into the Medicare/Medicaid Coordinated Plan will receive an integrated benefits program offered by a participating Medicare Advantage Organization (MAO). Medicaid will pay the premium for the integrated Medicare Advantage Plan* offered by a participating MAO. The integrated Medicare Advantage Plan will cover some services usually covered by Medicaid such as: primary care case management, prescribed drugs not covered by Medicare Part D, and dentures.

***Medicare Advantage Plans are health plans approved by Medicare but run by private**

companies referred to in this chapter as "MAOs."

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

For SFY 2007, a total cost of $128,000 is estimated for changes to Medicaid's automated system to support implementation of the coordinated plan benefit package. The cost to the State General Fund is estimated to be $12,800.

It is estimated that implementation of this benefit package will result in a savings of approximately $336,651 in SFY 2008, $743,501 in SFY 2009, and $1,231,526 in SFY 2010. No cost savings are anticipated for SFY 2007 because this benefit package will be implemented late in the fiscal year (April 2007).

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Sheila Pugatch at (208) 364-1817.

DATED this 20th day of February, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

IDAPA 16
TITLE 03
CHAPTER 17

16.03.17 - MEDICARE/MEDICAID COORDINATED PLAN BENEFITS

000. LEGAL AUTHORITY.

The Department is authorized to promulgate these rules under Sections 56-202(b), 56-251(2)(c), and 56-255(4), Idaho Code, the Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, Section 231, and Section 1937 of the Social Security Act. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." ( )

02. Scope. These rules cover the Medicaid benefit plan option that coordinates and integrates health plan benefits for individuals who are eligible for and enrolled in both Medicare and Medicaid. This package of benefits is referred to as the Medicare/Medicaid Coordinated Plan (MMCP). These rules cover eligibility, participant responsibility, general provider requirements, and the range of services covered under the MMCP. ( )

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

003. ADMINISTRATIVE APPEALS.

01. Administrative Appeals for Medicaid-Only Services. Administrative appeals to Medicaid are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

02. Medicare Advantage Organization Appeals and Grievance Processes. Appeals and grievances arising from MMCP services provided by participating MAOs must be filed with the Medicare Advantage Organization that enrolled the participant in the MMCP. ( )

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference in these rules. ( )

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. ( )

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

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

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

05. Internet Website Address. The website address is: http://www.healthandwelfare.idaho.gov. ( )

06. Division of Medicaid. The Division of Medicaid is located at 3232 Elder Street, Boise, Idaho 83705; Phone: (208) 334-5747. ( )

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*:* *( )*

a. A provider's reimbursement records*; and* *( )*

b. An individual's records covered by these rules. ( )

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. ( )

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, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

009. (RESERVED).

010. DEFINITIONS.
For the purposes of this chapter of rules, the following definitions are used: ( )

01. Capitated Payment. The amount paid to a Medicare Advantage Organization for Medicare/Medicaid Coordinated Plan services as expressed in a per member per month amount. ( )

02. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. ( )

03. Dual-Eligible. Individuals who meet all the eligibility requirements under Section 100 of these rules. ( )

04. Evidence of Coverage. The Medicare Advantage Plan contract the MAO has with the participant. This document explains the covered services, defines the Medicaid Advantage Plan obligations, and explains the participant's rights and responsibilities. ( )

05. Medicare. Medicare is a federal health insurance program for people age sixty-five (65) or older, people under age sixty-five (65) with certain disabilities, and people of all ages with End-Stage Renal Disease. It has three (3) types of coverage: Part A Hospital Insurance, Part B Medical Insurance, and Prescription Drug Coverage. It is administered under Title XVIII of the Social Security Act. ( )

06. Medicare Advantage Organizations (MAOs). Insurance companies approved by the Centers for Medicare/Medicaid Services to offer Medicare Advantage Plans in accordance with Title XVIII, Part C, of the Social Security Act and 42 CFR, Part 422, and who are Medicaid providers authorized to enroll participants in the Medicare/Medicaid Coordinated Plan. ( )

07. Medicare Advantage Plan. A health plan approved by Medicare but offered by a private company that contracts with Medicare to provide Medicare Part A, Part B, and Part D benefits. The Medicare Advantage Plan under this chapter is a special integrated plan offered by participating MAOs that includes the services listed under Section 301 of these rules. ( )

08. Medicare/Medicaid Coordinated Plan (MMCP). Medical assistance in which Medicaid purchases services from an MAO and provides other Medicaid-only services covered under the Medicaid Enhanced Plan in accordance with these rules. ( )

09. Medicaid. Idaho's Medical Assistance program administered under Title XIX of the Social Security Act. ( )

10. Medicaid Basic Plan. The medical assistance benefits included under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

11. Medicaid Enhanced Plan. The medical assistance benefits included under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

12. Medical Assistance. Payments made by Medicaid. ( )

011 -- 099. (RESERVED).

GENERAL PARTICIPANT PROVISIONS
(Sections 100 through 199)

100. MEDICARE/MEDICAID COORDINATED PLAN (MMCP) - PARTICIPANT ELIGIBILITY.
To be eligible to select the MMCP, the participant must meet the following criteria. ( )

01. Medicare Eligibility. The participant must be eligible for and enrolled in both Medicare Part A and Medicare Part B, and must not have Medicare eligibility due to End-Stage Renal Disease (ESRD). *( )*

02. Medicaid Eligibility. The participant must be eligible for medical assistance under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." The individual's Medicaid eligibility must not be based solely on the requirements found under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," Section 802, "Women Diagnosed With Breast or Cervical Cancer." ( )

03. Age. The participant must be age twenty-one (21) or older. ( )

101. MEDICARE/MEDICAID COORDINATED PLAN - PARTICIPANT ENROLLMENT.
To receive services under the MMCP, the participant must select and enroll with an MAO. ( )

102. MEDICARE/MEDICAID COORDINATED PLAN - PARTICIPANT RESPONSIBILITIES.
Participants who select the MMCP must comply with the following requirements: ( )

01. Selecting the Medicare/Medicaid Coordinated Plan. The participant must contact a participating MAO and request to sign up for the MMCP. Participation in the MMCP begins the month following the month the participant signs an application for the Medicare Advantage Plan that includes MAO-covered services listed under Section 301 of these rules. ( )

02. Compliance with Medicare Advantage Organization Requirements. The participant must comply with all of the requirements of the participating MAO, including the requirement to pay for services provided by out-of-network providers. Out-of-network providers are those who do not have a contract with the MAO with which the participant is enrolled. ( )

03. Notification to the Provider. ( )

a. The participant must present his Medicare Advantage card when seeking any of the services listed under Section 301 of these rules. ( )

b. The participant must present his Medicaid card when seeking any of the Medicaid-covered services listed under Section 302 of these rules. ( )

04. Termination of the Medicare/Medicaid Coordinated Plan. The participant can terminate his MMCP at any time. Coverage will continue until the end of the month in which the termination date falls. The participant will subsequently be automatically reenrolled in the Medicaid benefit plan, either Basic or Enhanced, in which they were initially enrolled. ( )

103. -- 199. (RESERVED).

GENERAL PROVIDER PROVISIONS
(Sections 200 Through 299)

200. PROVIDER APPLICATION PROCESS.
A prospective provider may apply for a provider number with the Department as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 200. ( )

201. -- 204. (RESERVED).

205. AGREEMENTS WITH PROVIDERS.
All provisions of IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, apply to providers of services under the MMCP. ( )

206. -- 209. (RESERVED).

210. CONDITIONS FOR PAYMENT.
All provisions of IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 210, apply to providers of services under the MMCP. ( )

211. -- 299. (RESERVED).

COVERED SERVICES
(Sections 300 through 303)

300. MEDICARE/MEDICAID COORDINATED PLAN - COVERAGE AND LIMITATIONS.
Medicare Advantage Plans and Medicaid are subject to applicable federal managed care requirements that provide participant protections regarding acceptable marketing activities, information regarding cost sharing, quality assurance, grievance systems, and participant rights. *( )*

01. MMCP-Covered Services. The MMCP-covered services include the following: ( )

a. MAO-Covered Services. Services covered by the MAO as listed under Section 301 of these rules. The MAO may limit or expand the scope of services as defined in the "Evidence of Coverage." ( )

b. Medicaid-Only Services. Services listed under Section 302 of these rules provided by Medicaid providers that are not MAOs. ( )

02. Services Excluded from the MMCP. Services not listed under Sections 301 or 302 of these rules are not covered under the MMCP. *( )*

03. Premiums and Cost-Sharing. The participant will not pay for any premiums or cost-sharing when covered under the MMCP, except as provided under Subsection 102.02 of these rules. ( )

301. MAO-COVERED SERVICES.
Under the MMCP, an MAO must cover, at a minimum, the following services: ( )

01. Inpatient Hospital Services. ( )

02. Outpatient Hospital Services. ( )

03. Emergency Room Services. ( )

04. Ambulatory Surgical Center Services. ( )

05. Physician Services. ( )

06. Other Practitioner Services. (Nurse Practitioner, Nurse Midwife, Chiropractor, Podiatrist, Physician Assistant). ( )

07. Prevention Services. (Adult Physicals, Screening Services). ( )

08. Laboratory and Radiological Services. ( )

09. Prescribed Drugs. (Medicare-Covered Drugs). ( )

10. Family Planning Services. ( )

11. Inpatient Psychiatric Services. ( )

12. Outpatient Mental Health Services. ( )

13. Home Health Care. ( )

14. Therapy Services. ( )

15. Speech, Hearing, and Language Services. ( )

16. Medical Equipment and Supplies. ( )

17. Prosthetic Devices. ( )

18. Vision Services. ( )

19. Dental Services. ( )

20. Primary Care Case Management. ( )

21. Prevention and Health Assistance Benefits. ( )

22. Medicare Part D Excluded Drugs Covered by Medicaid. ( )

23. Specialized Medical Equipment and Supplies. ( )

24. Dentures. ( )

25. Rural Health Clinic Services. ( )

26. Federally Qualified Health Center (FQHC) Services. ( )

27. Indian Health Clinic Services. ( )

302. MEDICAID-ONLY SERVICES.
Medicaid will cover the following services only if the MAO's "Evidence of Coverage" does not cover them: ( )

01. Psychosocial Rehabilitation (PSR). IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 123 through 146. ( )

02. Nursing Facility Services. IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 220 through 296. ( )

03. Personal Care Services (PCS). IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 300 through 308. ( )

04. Non-Emergency Transportation Services. IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 870 through 875. ( )

05. Home and Community Based (HCBS) Waiver Services. IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 326 and 703. ( )

06. Intermediate Care Facility Services for the Mentally Retarded (ICF/MR). IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 581 through 632. ( )

07. Developmental Disability Agency (DDA) Services. IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 650 through 656. ( )

303. MEDICARE/MEDICAID COORDINATED PLAN BENEFITS - PROVIDER REIMBURSEMENT.
Each provider must apply for and be approved as a Medicaid provider under the MMCP before it can be reimbursed. ( )

01. Medicaid-Only Service Providers. Medicaid-only service providers are reimbursed according to the reimbursement methodology in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," related to the Medicaid-only service. Medicaid-only service providers are also subject to the General Provider Provisions under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

02. Medicare Advantage Organizations. Each MAO will be paid a monthly per member per month (PMPM) rate that is defined in the Medicaid Provider Agreement. The MAO is responsible for submitting a monthly invoice to the Department in the Department-specified electronic format. This invoice must include the name of the Medicaid participant, the Medicaid ID number, and the time frame of coverage. The PMPM rate paid to the MAO includes the participant's Medicare premium, any cost-sharing required by the MAO, and the services listed under Section 301 of these rules. ( )

304. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.23 - RULES GOVERNING UNIFORM ASSESSMENTS FOR STATE-FUNDED CLIENTS

DOCKET NO. 16-0323-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 39-3308, 39-3508, and 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 pending rule is being adopted as proposed. The complete text of the proposed rule was published in the Wednesday, August 1, 2007, Idaho Administrative Bulletin, Vol. 07-8, pages 111 through 114. The companion rule for this docket published simultaneously under Docket No. 16-0310-0703.

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 to the state general fund related to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Susan Scheuerer at (208) 287-1156.

DATED this 20th day of September, 2007.

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@dhw.idaho.gov e-m

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 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 rulemaking procedures have been initiated. The action is authorized pursuant to Sections 39-3308, 39-3508, and 56-202(b), 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, August 15, 2007.

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

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

In the "Medicaid Enhanced Plan Benefits" chapter (IDAPA 16.03.10), a rule change is currently being proposed that will simplify the process for determining eligibility for nursing facility care. Specifically, the requirement that functional assessment scores (also known as the Minimum Data Set - MDS) submitted by nursing facilities be converted by Medicaid using its own scoring system (known as the Uniform Assessment Instrument - UAI) is being removed. Medicaid will accept the MDS scores submitted by nursing facilities as sufficient to determine that a participant needs nursing facility level of care. Medicaid will no longer convert MDS scores to UAI scores. This way, MDS scores will be used directly to determine medical eligibility for nursing facility care. This change will make the process more efficient, use less staff time, and result in more rapid eligibility determination while maintaining the same degree of accuracy.

Two rule changes are needed in this chapter to make it consistent with the changes being proposed in the "Medicaid Enhanced Plan Benefits" chapter.

1. **The term "nursing facilities" is being removed from the definition of "Supported Living Services Provider" since the Uniform Assessment Instrument (UAI) will no longer be used for nursing facility residents. The UAI will continue to be used for the rest of the supported living services providers listed in the definition.**

2. **The reference to the use of the UAI for nursing facility resident reassessments is also being removed since the MDS will be able to be used directly as a result of the changes in the "Medicaid's Enhanced Plan Benefits" chapter.**

In addition, the sections at the beginning of the chapter required by the Administrative

Procedure Act (APA) are being either updated or added where missing, to bring the rule chapter into compliance with the APA.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate because it confers a benefit.

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 is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes are being made to make the eligibility process easier for nursing facilities and more efficient for the Department. Informal discussions took place with the Idaho Health Care Association, the proposed changes were welcomed.

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

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 22, 2007.

DATED this 1st day of June, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

001. TITLE AND SCOPE.

01. Title. ~~*These rules are to be cited as the Rules of the Idaho Department of Health and Welfare*,~~ The title of these rules is IDAPA ~~*16, Title 03, Chapter*~~ 16.03.23, "Rules Governing Uniform Assessments for State-Funded Clients." ~~*(4-5-00)*~~(____)

02. Scope. These rules contain the minimum requirements and applied standards for uniform assessment of the functional and cognitive ability of persons who seek state-funded supported living services. (4-5-00)

002. WRITTEN INTERPRETATIONS.

~~*These rules are adopted to further the accuracy and consistency of placement and funding decisions affecting persons in supported living settings. The uniform assessment instrument shall be used to develop plans of care and, when required, negotiated service agreements, determine staffing ratios, to determine the capacity and expertise of the care provider to meet the needs of each client.*~~ There are no written interpretations for this chapter of rules. ~~*(4-5-00)*~~(____)

003. ADMINISTRATIVE APPEALS.
~~*Hearings will be conducted in conformance with the Department's*~~ Administrative appeals are governed by IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings~~*, IDAPA 16.05.03, Sections 100 through 102*~~." ~~*(4-5-00)*~~(____)

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

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE -- 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. (____)

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

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

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

05. Internet Website Address. The website address is: http://www.healthandwelfare.idaho.gov. (____)

06. Division of Medicaid. The Department's Division of Medicaid is located at 3232 Elder Street, Boise, ID 83705; Phone: (208) 334-5747. (____)

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. (____)

007. -- 009. (RESERVED).

0~~04~~10. DEFINITIONS.

For the purposes of these rules, the following terms are used as defined below: (____)

01. Activities of Daily Living. Bathing, dressing, toileting, transferring, eating, and walking. (4-5-00)

02. Client. A person for whom the State of Idaho, or a program administered by the State of Idaho, pays all or any part of the cost of the person's care. (4-5-00)

03. Department. The Idaho Department of Health and Welfare. (4-5-00)

04. Instrumental Activities of Daily Living. Meal preparation, money management, transportation, shopping, using the telephone, medication management, heavy housework, and light housework. (4-5-00)

05. Service Plan. A plan that describes the type and quantity of services that will be provided to a client, whether called a plan of care, plan for care, negotiated services agreement, individual support plan, or by some other name. (4-5-00)

06. Significant Change in Client's Condition. A major change in the client's status that affects more than one area of the client's functional or health status, and requires review or revision of the care plan or negotiated service agreement. (4-5-00)

07. Supported Living Services. Assistance with activities of daily living, instrumental activities of daily living, and supervision to enable a client to reside safely in the setting of the client's choice. (4-5-00)

08. Supported Living Services Provider. A facility or person that provides supported living services. Such facilities and persons include ~~*nursing facilities,*~~ residential care and assisted living facilities, certified family homes, specialized family homes, personal care service providers, semi-independent facilities, intermediate care facilities for persons with mental retardation, and home and community-based services waiver providers. ~~*(4-5-00)*~~(____)

09. Uniform Assessment. A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities. For participants using the Developmental Disabilities and Idaho State School and Hospital Waiver services, and adults using Developmental Disabilities Agency services or Targeted Service Coordinator services, or both, the requirement for a uniform assessment is met by the assessment and history required under IDAPA 16.03.13, "Prior Authorization for Behavioral Health Services." (3-20-04)

~~***005. 010. (RESERVED).***~~

011. COMPLETION OF THE UNIFORM ASSESSMENT INSTRUMENT.

01. Department's Responsibility for the Uniform Assessment of Clients. The Department ~~*shall*~~ will assess or direct the uniform assessment of clients age eighteen (18) or older who seek supported living services. ~~*(4-5-00)*~~(____)

02. Qualifications of Persons Making Uniform Assessments. The uniform

assessment ~~*shall*~~ must be conducted by persons who are trained by the Department in the use of the uniform assessment instrument. ~~*(4-5-00)*~~(____)

03. Payment Conditioned on Completion of Assessment. A uniform assessment must be completed as a condition of state payment for supported living services. The Department will not authorize payment for services to a client if the services were rendered prior to the completion of a uniform assessment instrument for that client, unless the Department determines it was beyond the control of the supported living services provider and it is justified by the individual circumstances. In addition, other Department payment requirements must be met. (4-5-00)

04. Time Period for Completing the Assessment. The Department will prioritize pending assessments, and expedite assessments that, in its discretion, it considers emergencies, including reassessments of clients whose needs have changed. (4-5-00)

05. Reassessments. A client ~~*shall*~~ must be reassessed if there is a significant change in the client's condition, or annually, whichever occurs first. ~~*For nursing facility residents, after an initial UAI is completed, the federal minimum data set may be substituted for the uniform assessment instrument.*~~ ~~*(4-5-00)*~~(____)

012. USE OF THE UNIFORM ASSESSMENT INSTRUMENT IN DEVELOPING THE CLIENT'S SERVICE PLAN.
The client's unmet needs as identified by the uniform assessment instrument ~~*shall*~~ must be used to develop a service plan. ~~*(4-5-00)*~~(____)

013. USE OF THE UNIFORM ASSESSMENT INSTRUMENT IN DETERMINING FACILITY STAFFING RATIOS.
A supported living services provider ~~*shall*~~ must have sufficient numbers and types of staff to carry out each client's service plan based on the uniform assessment instrument and to comply with all other rules governing the provider. ~~*(4-5-00)*~~(____)

014. USE OF THE UNIFORM ASSESSMENT INSTRUMENT FOR DETERMINING THE ABILITY OF THE SUPPORTED LIVING SERVICES PROVIDER TO MEET CLIENTS' NEEDS.
The information from the uniform assessment instrument ~~*shall*~~ will be used to determine the ability of a supported living services provider to meet the identified needs of the client. The information from the uniform assessment instrument ~~*shall*~~ will also be used to determine the need for special training or licenses that may be required in caring for certain clients. ~~*(4-5-00)*~~(____)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.01 - USE AND DISCLOSURE OF DEPARTMENT RECORDS

DOCKET NO. 16-0501-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 9-340(B), 39-242, 39-5403, 56-221, 56-222, 56-1003 and 56-1004, Idaho Code; and 45 CFR 164.502(g)(4).

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 5, 2007 Idaho Administrative Bulletin, Vol. 07-9, pages 166 through 172.

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, contact Jeanne Goodenough, Deputy Attorney General at (208) 334-5537.

DATED this 5th day of November, 2007.

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@dhw.idaho.gov e-mail

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0501-0701***
Use and Disclosure of Department Records ***PENDING 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 9-340(B), 39-242, 39-5403, 56-221, 56-222, 56-1003 and 56-1004, Idaho Code; and 45 CFR 164.502(g)(4).

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 19, 2007.

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 following changes are being made in this rulemaking:

1. **The list of individuals whose identity must not be disclosed because they have reported concerns about the Department's responsibilities is being expanded to include individuals who may report concerns about certified family homes.**
2. **Individuals and organizations licensed by the Department are being added to the list of exceptions to requirements for authorizations.**
3. **The list of law enforcement personnel (coroners, medical examiners, funeral directors, or personal representatives) who have access to the records of decedents is being revised to include the purpose for which they may use the disclosed information.**

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:

This rulemaking has no fiscal impact to the general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this rule change is being made due to an amendment to Idaho Code and in order to align the rule with federal code.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jeanne Goodenough, Division Chief, Deputy Attorney General at (208) 334-5537.

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 26, 2007.

DATED this 31st day of July, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

051. AUTHORIZATION FOR THE USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION.
An authorization for the use and disclosure of ~~*health and other*~~ confidential information must be in writing, and identify the individual who is the subject of the record. ~~*(3-20-04)*~~(____)

01. Content of Authorization. An authorization must be dated and signed by the individual or legal representative, and: (3-20-04)

a. Identify the specific information involved; (3-20-04)

b. State the duration of the authorization, defined by a specific date or the description of an event; (3-20-04)

c. Identify the recipient of the information; and ~~*(3-20-04)*~~(____)

d. State the purpose for the authorization~~;~~, or state that it is, "At the request of the individual," or similar wording. ~~*(3-20-04)*~~(____)

~~**e.** *Specify any restrictions on use or disclosure of the information; and* *(3-20-04)*~~

~~**f.** *Provide for revocation of the authorization.* *(3-20-04)*~~

02. Defective Authorization. An authorization must not be acted upon if the authorization has expired or has been revoked, or if any essential information is omitted or is false. (3-20-04)

03. Authorization for the Use and Disclosure of Health Information. An authorization for the use and disclosure of health information must contain the content listed in Subsection 051.01 and the statements required by 45 CFR 164.508(c)(2). (____)

0~~3~~4. Psychotherapy Notes. Psychotherapy notes that are separate from the rest of an individual's record may not be used or disclosed without an authorization except to the originator of the notes for treatment or to defend the Department in a legal action brought by the individual. (3-20-04)

0~~4~~5. Revocation of an Authorization. An individual or legal representative may revoke an authorization at any time by submitting a written request at any Department office. (3-20-04)

0~~5~~6. Effect on Benefits and Services. An individual's refusal to provide an authorization does not affect the receipt of benefits or services the individual would otherwise receive. (3-20-04)

0~~6~~7. Copy of Authorization. The Department will provide a copy of the signed authorization to the individual or legal representative. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

075. USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION.
Without a consent or an authorization, no one may use or disclose health or other confidential information except as provided in Section 100 of this chapter. With a consent or an authorization, confidential information will be used or disclosed only on a need-to-know basis and to the extent minimally necessary for the conduct of the Department's business and the provision of benefits or services, subject to law and the exceptions listed in these rules. Recipients of information must protect against unauthorized disclosure or use of the information for purposes that are not specified in a consent or an authorization. Access to an individual's own records is governed by Section 125 of this chapter. Specific consent and disclosure requirements are identified in Sections 200 through 283 of these rules. (3-20-04)

01. Identity. Any individual who requests to review, copy, restrict or amend confidential information, or to sign an authorization, must provide verification of identity, and where appropriate, present proof that the individual is a legal representative of the subject of the record. Except for verifications or requests for certified copies of vital records, requests submitted by mail must be notarized if necessary to identify the individual's signature. (3-20-04)

02. Order of Court or Hearing Officer. If information is subpoenaed in a civil, criminal or administrative action, the Department will provide such information as would be disclosed with a public records request, without an order from the court or hearing officer. Alternatively, the Department may submit the record with a request for a review solely by the judge or hearing officer, and an order appropriately limiting its use by the parties. If Department staff have reason to believe that release of a record through a public records request may be detrimental to any individual, the Department may seek a protective order. (3-20-04)

03. Referent. Unless the individual is a witness in litigation, identifying information must not be disclosed about an individual who reported concerns relating to any Department ~~*function*~~ responsibility, including: ~~(3-20-04)~~(____)

a. Fraud; (3-20-04)

b. Abuse, neglect or abandonment of a child; (3-20-04)

c. Abuse, neglect or abandonment of a vulnerable adult; ~~*and*~~ ~~(3-20-04)~~(____)

d. Concerns about the mental health of another~~.~~; and ~~(3-20-04)~~(____)

e. Certified family homes, unless the complainant consents to disclosure in writing or disclosure is required in any administrative or judicial proceeding, in compliance with Section 9-340B(16), Idaho Code. ( )

04. Collateral Contact. Identifying information must not be disclosed about individuals who are not the subject of the record and who provide information to the Department in the ordinary course of business. (3-20-04)

05. Alternative Communication. The Department, contractors and providers must comply with an individual's request that confidential information be communicated by alternative means of delivery unless it is administratively difficult to do so or the request is unreasonable. If approved, all information from a Department program will use the same alternative means of delivery after the request is received and recorded. (3-20-04)

06. Restriction on Disclosure of Health Information. (3-20-04)

a. An individual may request in writing that use or disclosure of health information be restricted. The Department will respond in writing, and may deny the request if: (3-20-04)

i. Disclosure is required; (3-20-04)

ii. Necessary for the safety of the individual or others; (3-20-04)

iii. Necessary for the provision of services, benefits or payment; or (3-20-04)

iv. The restriction is unreasonable. (3-20-04)

b. The uses and disclosures of confidential information are subject to a restriction after it is received and recorded by the Department. Department employees, contractors, and the individual may request the Department to terminate the restriction. The Department will notify the individual of its response to a request to terminate a restriction. (3-20-04)

07. Discovery. Records will be provided only in response to valid discovery in any federal or state criminal, civil or administrative proceeding, as required by the Public Records Act, Section 9-343(3), Idaho Code. (3-20-04)

~~***08. "Do Not Re-Release" Records**. If the Department receives health information that is marked "Do not re-release," that information will not be disclosed except to the subject of the record or legal representative, if allowed by these rules or applicable law. (3-20-04)***~~

076. -- 099. (RESERVED).

100. EXCEPTIONS TO REQUIREMENT FOR AUTHORIZATION.
Confidential information will be released without an authorization to individuals and entities in compliance with a court order, or if they are legally authorized to receive it. The following are exceptions to the requirement for an authorization: (3-20-04)

01. Advocates and Guardians. Federally-recognized protection and advocacy

agencies or duly appointed guardians ad litem have access to an individual's file as necessary to perform their legal functions. Guardians ad litem have access to records as provided in Section 16-1623, Idaho Code, except for: (3-20-04)

a. Drug abuse and sickle cell anemia records maintained by the Veteran's Administration (VA), as required by 38 USC Section 7332; (3-20-04)

b. Claims under laws administered by the VA as required by 38 USC Section 3301; and (3-20-04)

c. Drug abuse prevention programs that receive federal assistance, as required by 42 USC Section 290ee - 3. (3-20-04)

02. ~~***Police Functions****. Police officers and sheriffs are entitled to receive confidential information for the purpose of conducting an investigation, or to determine whether to place an individual in protective custody, subject to limitations regarding substance abuse treatment.*~~ **Licensure**. In compliance with Section 9-340C(9), Idaho Code, records will be released if they are part of an inquiry into an individual's or organization's fitness to be granted or retain a license, certificate, permit, privilege, commission or position. These records will otherwise be provided in redacted form as required by law or rule. ~~*(3-20-04)*~~( )

03. Fugitives and Missing Persons. (3-20-04)

a. A state or local law enforcement officer may receive the current address of any cash assistance recipient who is a fugitive felon, in compliance with Section 56-221, Idaho Code. (3-20-04)

b. The following health information may be disclosed to a law enforcement officer for the purpose of identifying or locating a suspect, fugitive, material witness or missing person: (3-20-04)

i. Name and address; (3-20-04)

ii. Date and place of birth; (3-20-04)

iii. Social security number; (3-20-04)

iv. Blood type and rh factor; (3-20-04)

v. Type of injury; (3-20-04)

vi. Date and time of treatment or death, if applicable; and (3-20-04)

vii. Distinguishing physical characteristics. (3-20-04)

c. DNA, dental records, or typing, samples or analysis of body fluids or tissue must not be disclosed. (3-20-04)

04. Duty to Warn or Report. Confidential information may be released without an authorization if necessary under a legal duty to warn or to report. (3-20-04)

05. Department Business, Monitoring and Legal Functions. Department employees and contractors may use and disclose records as necessary to perform normal business functions, including health treatment, audit and quality improvement, investigation of fraud and abuse, establishment of overpayments and recoupment, public health, or other functions authorized by law. Information will be made available to state and federal auditors and compliance monitors. Confidential information will be provided to counsel as needed to evaluate, prepare for and represent the Department in legal actions. (3-20-04)

06. Emergencies. Confidential information may be disclosed to qualified medical personnel to the extent necessary to respond to a medical emergency that requires immediate attention. (3-20-04)

07. Multidisciplinary Staffing. Confidential information may be disclosed to employees of the Department, law enforcement, and other appropriate individuals to participate in a multidisciplinary team evaluation of child protection cases under Section 16-1609A, Idaho Code, or interdisciplinary Department staffing of services for an individual. All individuals who participate in such staffing must not redisclose the information and must comply with any other pertinent statute, rule or regulation. (3-20-04)

08. Collaborative Staffing. Confidential information may be disclosed in staffing by the Department and other individuals or entities if all participants are involved with the same or similar populations and have an equal obligation or promise to maintain confidentiality. Disclosure of information in inter-agency staffing must be necessary to coordinate benefits or services, or to improve administration and management of the services. Confidential information may be disclosed only on a need-to-know basis and to the extent minimally necessary for the conduct of the staffing. All individuals who participate in such staffing must not redisclose the information except in compliance with any other pertinent statute, rule or regulation. (3-20-04)

09. Elected State Official. As provided by Section 16-1623(f), Idaho Code, any duly elected state official carrying out his official functions may have access to child protection records of the Department, and must not redisclose the information. (3-20-04)

10. Child Protection Agency. A legally mandated child protection agency may provide information necessary to investigate a report of known or suspected child abuse or neglect, or to treat a child and family who are the subjects of the record. (3-20-04)

11. Legally Authorized Agency. An agency will be provided appropriate information if the agency is legally responsible for or authorized to care for, treat or supervise a child who is the subject of the record. (3-20-04)

12. Informal Representatives. Informal representatives may be permitted to receive and deliver information on behalf of an individual, and may be given health information if the informal representative is directly involved with the individual's care. Confidential information may be withheld in whole or part if professional staff determines that disclosure is not in the best interest of the individual, based on the circumstances and their professional judgement. The

Department will not disclose information that is prohibited from being disclosed by these rules or any other legal requirement. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

125. ACCESS TO AN INDIVIDUAL'S OWN RECORD.
An individual who is at least fourteen (14) years old, or a legal representative, may review and obtain a copy of Department records that pertain to the individual, subject to the exceptions listed in Subsections 125.01 through 125.04 of these rules. Requests must be in writing, identifying the individual whose record is sought, and the record or information requested. The principles of disclosing only minimally necessary information on a need-to-know basis do not apply to a request for an individual's own records. The following information must not be disclosed: (3-20-04)

01. Children's Mental Health. Records of a child's mental health services must not be disclosed to the child when a physician or other mental health professional has noted that disclosure would be damaging to the child, unless access is ordered by a court according to Section 16-2428, Idaho Code. (3-20-04)

02. Legal Action. No disclosure will be made to an individual of information compiled in an ongoing investigation, that is exempt from disclosure, or that relates to adoption. Information compiled in reasonable anticipation of litigation that is not otherwise discoverable must not be disclosed. Information compiled for use in a civil, criminal, or administrative proceeding to which the individual is a party must not be disclosed except in compliance with valid discovery. (3-20-04)

03. Clinical Laboratories. There will be no disclosure of information maintained by a clinical laboratory except as authorized by the provider who ordered the test or study, in compliance with 42 USC 263a. ~~*(3-20-04)*~~( )

04. Confidential Information. Health and other confidential information will not be disclosed to the individual if a licensed professional in an appropriate discipline determines that disclosure is likely to endanger the life or physical safety of the individual or another person. Disclosure to a legal representative will be denied if there is a professional determination that access by the representative is likely to cause substantial harm to the subject of the record or another person. (3-20-04)

(BREAK IN CONTINUITY OF SECTIONS)

190. RECORDS OF DECEDENTS.
Records of decedents are confidential for as long as the Department maintains the records, except as needed by: ~~*coroners or medical examiners, funeral directors, and law enforcement if there is suspicion that the death was the result of criminal conduct. While records are maintained, the same confidentiality requirements apply to the personal representative of the estate or other legal representative of the deceased individual.*~~ ~~*(3-20-04)*~~( )

01. Law Enforcement. If there is suspicion that the death was the result of criminal conduct. ( )

02. Coroners and Medical Examiners. Information may be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. ( )

03. Funeral Directors. Confidential information may be given to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary to carry out their duties, confidential information may be disclosed to funeral directors prior to and in reasonable anticipation of the individual's death. ( )

04. Personal Representatives. While records are maintained, the same confidentiality requirements apply to the personal representative of the estate or other legal representative of the deceased individual. Information may be disclosed to such representatives only to the extent necessary to perform their legal function, ( )

(BREAK IN CONTINUITY OF SECTIONS)

210. CHILD PROTECTION.
Unless allowed by these rules or other provision of law, the Department will disclose information from child protection records in its possession upon a court order obtained in compliance with Subsection 075.02 of these rules. Disclosure of Department records under the Child Protective Act is governed by Section 16-162~~3~~9(~~f~~6), Idaho Code. Court records of Child Protective Act proceedings are governed by Section 16-162~~1~~6, Idaho Code. Pertinent federal laws and regulations include 42 USC 5106 and 45 CFR 134.20. Information regarding child fatalities or near fatalities is required to be made public by 42 USC 5106a(b)(2)(A)(~~vi~~x). ~~(3-20-04)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

230. MEDICAL CARE.
Consent to apply for services or treatment is governed by Chapter 4~~3~~5, Title 39, Idaho Code, for hospital, medical, dental or surgical care, treatment or procedure. ~~(3-20-04)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

242. SPECIFIC REQUIREMENTS - PROTECTION AND ADVOCACY AGENCIES.
A protection and advocacy system for individuals who have a developmental disability is created by 42 USC 15042 et seq.; for individuals with mental illness, by 42 USC 10801. Advocacy for adult protection is governed by Sections 39-5307 and 39-5308, Idaho Code. ( )

24~~2~~3. -- 249. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.05 - CRIMINAL HISTORY AND BACKGROUND CHECKS IN LONG-TERM CARE SETTINGS

DOCKET NO. 16-0505-0701 (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 2008 Idaho State Legislature for final approval. Pursuant to Section 67-5224(5)(c), Idaho Code, this pending rule will not become final and effective until it has been approved, amended, or modified by concurrent resolution of the legislature because of the fee being imposed or increased through this rulemaking. 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 56-1004A, 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 proposed rule will repeal this chapter. The complete text of the proposed rule was published in the September 5 Idaho Administrative Bulletin, Vol. 07-9, page 174.

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

These rules were adopted by the Department to participate in a federal grant pilot project for criminal history and background checks in long-term care settings. The pilot project and grant money that cover the costs for these criminal history and background checks expired on September 30, 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:

The fiscal impact of the repeal of this chapter is cost neutral. Federal grant money is no longer available, but the cost of a criminal history and background check is required to be paid for by the applicant under Section 56-1004A, Idaho Code.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mond Warren at (208) 334-5997.

DATED this 1st day of November, 2007.

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0505-0701***
Criminal History/Background Checks/Long-Term Care Settings ***PENDING RULE***

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 NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 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 rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), and 56-1004A, 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 19, 2007.

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:

These rules were adopted by the Department to participate in a federal grant pilot project for criminal history and background checks in long-term care settings. The pilot project and grant money that cover the costs for these criminal history and background checks expire on September 30, 2007. These rules are no longer needed and are being repealed.

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

These rules are no longer necessary, because of the salutatory expiration of the long-term care pilot project in Section 56-1004A, Idaho Code.

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 of the repeal of this chapter is cost neutral. Federal grant money is no longer available, but the cost of a criminal history and background check is required to be paid for by the applicant under Section 56-1004A, Idaho Code.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because of the expiration of the federal grant and pilot project that these rules governed.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Mond Warren at (208) 334-5997.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before September 26, 2007.

DATED this 16th day of July, 2007.

IDAPA 16.05.05 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.01 - RULES GOVERNING FAMILY AND CHILDREN'S SERVICES

DOCKET NO. 16-0601-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 16-1629, 56-202(b), and 56-1003, 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 5, 2007, Idaho Administrative Bulletin, Vol. 07-9, pages 183 through 190.

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:

One-time costs projected to revise the Central Registry portions of the Department's child welfare information system known as FOCUS (Family-Oriented Community User System) are estimated at $40,000; these costs would be covered using existing federal funds. A cost of $30,000 to state general fund monies is estimated for contract or temporary staff resources to provide retrospective case-by-case reviews for those individuals currently on the registry who petition for removal.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Shirley Alexander at (208) 334-6618.

DATED this 5th day of November, 2007.

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@dhw.idaho.gov e-mail

DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0601-0701***
Rules Governing Family and Children's Services ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 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 rulemaking procedures have been initiated. The action is authorized pursuant to Sections: 16-1629, 56-202(b), 56-1003, Idaho Code.

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

Monday, September 17, 2007 at 6:00 pm
DHW - Region I Office
1250 Ironwood, Conference Room
Coeur d'Alene, ID

Tuesday, September 18, 2007 at 6:00 pm
DHW - Region III Office
3402 Franklin Road
Caldwell, ID

Monday, September 17, 2007 at 6:00 pm
DHW - Region IV Office
1720 Westgate Drive
Suite D, Room 119, Boise, ID

Wednesday, September 19, 2007 at 6:00 pm
Human Development Center
421 Memorial Drive
Pocatello, ID

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

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

The Department's Child Protection Central Registry contains the names of individuals for whom a report of child abuse, abandonment, or neglect has been substantiated by the Department. The purpose of the Central Registry is to aid the Department in protecting children from individuals who have previously abused, abandoned, or neglected children. Any individual who has a substantiated report in the Central Registry may be denied: (1) employment that involves direct care of children or vulnerable adults, (2) a license to provide child care or foster care, and (3) adoption of a child.

The names on the Central Registry are confidential and may only be released with written consent of the individual requesting a criminal history and background check. No information is released regarding the severity or type of child abuse or neglect.

Beyond the initial appeal process available to an individual newly-placed on the Central Registry, there is currently no provision in the rule for an individual to have his name removed from the registry. There is an exemption process that may "clear" a person to work, be licensed or adopt, but it does not remove the individual's name from the registry.

This issue has resulted in numerous complaints from the public.

The Department is proposing rule changes that include a new system for classifying the level of risk to children posed by individuals with substantiated reports of abuse, abandonment, or neglect. The rule changes will also include a process for an individual on the Central Registry to request that the Department remove his name from the registry when the time period assigned to the individual's risk level has elapsed.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to protect the public health, safety, or welfare.

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.

One-time costs projected to revise the Central Registry portions of the Department's child welfare information system known as FOCUS (Family-Oriented Community User System) are estimated at $40,000; these costs would be covered using existing federal funds. A cost of $30,000 to state general fund monies is estimated for contract or temporary staff resources to provide retrospective case-by-case reviews for those individuals currently on the registry who petition for removal.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because changes are being made simply to reflect the revised business process for the Central Registry.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Shirley Alexander at (208) 334-6618.

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, September 26, 2007.

DATED this 11th day of July, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
The Idaho Legislature has delegated to the Department, or the Board of Health and Welfare, or

both jointly, the responsibility to establish and enforce such rules and methods of administration as may be necessary or proper to administer social services to people who are in need, under the following Sections: 16-162~~3~~9, 16-2102, 16-2406, 16-2423, 16-2433, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-203B, 56-204A, 56-803, 56-1003, 56-1004, and 56-1004A, Idaho Code. ~~(3-30-07)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

550. CHILD PROTECTION SERVICES.
Sections 56-204A, 56-204B, 16-1601, 16-162~~3~~9 and 16-2001, Idaho Code, make the Department an official child protection agency of state government dealing with ~~*a duty to intervene in*~~ situations of reported child ~~*neglect,*~~ abuse, ~~*or*~~ abandonment, or neglect. A respectful, non-judgmental approach should be the policy for assessments, especially during the initial contact with the family. Training in communication would include multicultural and diversity issues and interest-based conflict resolution. ~~(3-30-01)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

560. DISPOSITION OF CHILD PROTECTION REPORTS.
Within five (5) days following completion of risk assessments, the Department ~~*shall*~~ will determine whether the reports are substantiated or unsubstantiated. ~~*The substantiation of reports shall be determined using the following definitions, with consideration given to the age of the child, extenuating circumstances, prior history, parental attitude toward discipline, and severity of abuse or neglect:*~~ All persons who are the subject of a child protection risk assessment will be notified of the disposition of the assessment. ~~(5-3-03)~~(____)

01. Substantiated. Child abuse, ~~*and*~~ abandonment, or neglect reports are ~~*confirmed*~~ substantiated by one (1) or more of the following: ~~(5-3-03)~~(____)

a. Witnessed by a family services worker, as defined in Section 011 of these rules; ~~(5-3-03)~~(____)

b. ~~*Determined or evaluated by a*~~ A court determines that a child comes within the jurisdiction of the Child Protective Act, Title 16, Chapter 16, Idaho Code; ~~(3-30-01)~~(____)

c. A confession; ~~*or*~~ ~~(3-30-01)~~(____)

d. Corroborated by physical or medical evidence; or (____)

~~**d**~~**e.** ~~*Validated through the presence of significant evidence that establishes a clear factual foundation for the determination of "substantiated."*~~ Established by evidence that would lead a reasonable person to conclude, that it is more likely than not that abuse, abandonment, or

neglect occurred. ~~(5-3-03)~~(____)

02. Unsubstantiated. Child abuse, ~~and~~ abandonment, or neglect reports ~~that cannot be found substantiated~~ are unsubstantiated when they are not found to be substantiated under Subsection 560.01 of this rule. For intradepartmental statistical purposes, the Department will indicate whether the unsubstantiated disposition of the risk assessment was due to: ~~(5-3-03)~~(____)

a. Insufficient evidence; or (5-3-03)

b. ~~Facts indicate that the report is~~ An erroneous ~~or otherwise unfounded~~ report. ~~(5-3-03)~~(____)

561. ~~SUBSTANTIATED REPORTS~~ CHILD PROTECTION CENTRAL REGISTRY.
~~For reports determined to be "substantiated," the appropriate information shall be entered into the Department's Central Registry for the reporting of child abuse, abandonment and neglect, and the alleged perpetrator so advised in writing. Notification will include how the individual can appeal to have the disposition status changed. The Department shall remove identifying information regarding a specific individual only when that individual has successfully appealed his name being placed on the Central Registry.~~ The Adam Walsh Child Protection and Safety Act of 2006, P.L. 109-248, July 27, 2006, 120 Stat. 587, has directed the states to establish a central registry for the purpose of sharing information about persons who have substantiated reports of abuse, abandonment, or neglect against children. The Child Protection Central Registry was established under the authority of Section 16-1629(3), Idaho Code. The primary purpose of the Child Protection Central Registry is to aid the Department in protecting children and vulnerable adults from individuals who have previously abused, neglected, or abandoned children. The Child Protection Central Registry maintained by the Department is separate and apart from the central registry for convicted sexual offenders maintained by the Idaho State Police under Title 18, Chapter 83, Idaho Code. The Child Protection Central Registry provisions in this chapter of rules apply to risk assessments conducted by the Department after October 1, 2007. ~~(5-3-03)~~(____)

562. CONFIDENTIALITY OF THE CHILD PROTECTION CENTRAL REGISTRY.
The names on the Child Protection Central Registry are confidential and may only be released with the written consent of the individual requesting a criminal history and background check, unless otherwise required by federal or state law. No information is released regarding the severity or type of child abuse, abandonment, or neglect. (____)

563. SUBSTANTIATED REPORTS ON THE CHILD PROTECTION CENTRAL REGISTRY.
The name of an individual for whom an incident of abuse, abandonment, or neglect has been substantiated will be entered into the Child Protection Central Registry based on the designated level of risk. The level of risk will be determined by the severity and type of the abuse, abandonment, or neglect and the potential risk of future harm to a child. The highest level of risk is designated as Level One (1) and the lowest level of risk is Level Four (4). After an individual has been placed on the Child Protection Central Registry, the Department will notify him in writing that he has been placed on the registry, the risk level assigned and the basis for the Department's decision, the procedures for filing an appeal under IDAPA 16.05.03. "Rules Governing Contested Case Proceedings and Declaratory Rulings," and the procedures for filing a

petition for removal from the Child Protection Central Registry in accordance with Section 564 of these rules. ( )

01. **Child Protection Level One**. An individual with a Level One (1) designation has been determined to pose a high to severe risk to children. Names of individuals for whom an incident of abuse, abandonment, or neglect has been substantiated for any of the following will remain permanently on the Child Protection Central Registry at Level One (1). ( )

a. Sexual Abuse as defined in Section 16-1602(1)(b), Idaho Code; ( )

b. Sexual Exploitation as defined in Sections 18-1506 and 18-1507, Idaho Code; ( )

c. Physical abuse as described in Section 16-1602(1)(a), Idaho Code, that causes life-threatening, disabling, or disfiguring injury or damage; ( )

d. Neglect as described in Section 16-1602(25), Idaho Code, that results in life-threatening, disabling, or disfiguring injury or damage; ( )

e. Abandonment as described in Section 16-1602(2), Idaho Code, that results in life-threatening, disabling, or disfiguring injury or damage; ( )

f. Death of a child; ( )

g. Torture of a child as described in Section 18-4001, Idaho Code; ( )

h. Aggravated Circumstances as described in Section 16-1619(6)(d), Idaho Code; or ( )

i. Occurrence of two (2) or more separate, substantiated incidents of abuse, abandonment, or neglect, each of which falls under the circumstances listed under Subsection 563.02 of this rule. ( )

02. **Child Protection Level Two**. An individual with a Level Two (2) designation has been determined to pose a medium to high risk to children and will remain on the Child Protection Central Registry for a minimum of ten (10) years. After the end of the ten (10) year period, an individual may petition the Department to request his name be removed from the Child Protection Central Registry in accordance with Section 564 of these rules. Names of individuals for whom an incident of abuse, abandonment, or neglect has been substantiated for any of the following will be given the designation of Level Two (2). ( )

a. Prenatal use of any controlled substance as defined under Section 37-2701(e), Idaho Code, except as prescribed by a medical professional; ( )

b. Administering or knowingly allowing a child to absorb or ingest one (1) or more controlled substances as defined under Section 37-2701(e), Idaho Code, except in the amount prescribed for the child by a medical professional; ( )

c. Child exposed to potentially dangerous: ( )

i. Drug paraphernalia, as defined in Section 37-2701(n), Idaho Code; ( )

ii. Manufacture of controlled substances, as defined under Section 37-2701(e), Idaho Code, and Section 37-2701(r), Idaho Code; or ( )

iii. Chemical components used in the manufacture of controlled substances, as defined under Section 37-2701(e), Idaho Code. ( )

d. Failure to thrive caused by abuse, abandonment, or neglect, as established by medical evidence; ( )

e. Physical abuse as described in Section 16-1602(1)(a), Idaho Code, abandonment as described in Section 16-1602(2), Idaho Code, or neglect as described in Section 16-1602(25), Idaho Code, that results in neither disabling nor disfiguring injury or damage, but may require medical or other treatment; ( )

f. The restraint or confinement of a child that is potentially dangerous or poses a substantial risk of causing life-threatening, disabling, or disfiguring injury or damage; ( )

g. Medical neglect as described in Section 16-1602(25), Idaho Code, that is potentially dangerous or poses a substantial risk of resulting in life-threatening, disabling, or disfiguring injury or damage; ( )

h. Malnutrition as established by medical evidence; or ( )

i. Occurrence of two (2) or more separate, substantiated incidents of abuse, abandonment, or neglect, each of which falls under the circumstances listed under Subsection 563.03 of this rule. ( )

03. Child Protection Level Three. An individual with a Level Three (3) designation has been determined to pose a mild to medium risk to children and will remain on the Child Protection Central Registry for a minimum of five (5) years. After the end of the five (5) year period, an individual may petition the Department to request his name be removed from the Child Protection Central Registry in accordance with Section 564 of these rules. Names of individuals for whom an incident of abuse, abandonment, or neglect has been substantiated for any of the following are given the designation of Level Three (3). ( )

a. Lack of supervision that is potentially dangerous; ( )

b. Failure to protect from abuse, abandonment, or neglect as described in Section 16-1602, Idaho Code, that is potentially dangerous; ( )

c. Failure to discharge parental responsibilities described under Section 16-1602(23), Idaho Code, in situations that are potentially dangerous or pose a substantial risk of harm to the health, safety, welfare, or well-being of a child; or ( )

d. Physical abuse as described in Section 16-1602(1)(a), Idaho Code, or neglect as described in Section 16-1602(25), Idaho Code, that causes minor injuries or damage that does not require medical treatment. ( )

04. Child Protection Level Four. An individual with a Level Four (4) designation has been determined to pose a low risk of future harm to children and will not be placed on the Child Protection Central Registry. Names of individuals who are substantiated for any of the following are given the designation of Level Four (4). ( )

a. Mild physical neglect due to poverty issues, including no heat or utilities; ( )

b. Minor injury of a child while parent was attempting to protect himself or another; ( )

c. Unsanitary house with timely clean up; or ( )

d. Circumstances in which parent(s) cannot safely provide for their child because the child poses a threat to the safety of the parent(s) or other children in the home and the parent(s) are actively working with the Department or other agency to find a safe and appropriate placement solution for the child. ( )

564. PETITIONING FOR REMOVAL FROM THE CHILD PROTECTION CENTRAL REGISTRY.

01. Petitioning for Removal From the Child Protection Central Registry. Any individual whose name appears on the Child Protection Central Registry, other than an individual with a Level One (1) designation, may, after the applicable minimum period of time has passed, petition to have his name removed from the Child Protection Central Registry. The petition must include a written statement from the petitioner to the Department's FACS Division Administrator requesting that the petitioner's name be removed from the Child Protection Central Registry. The petition will be granted if: ( )

a. There are no additional substantiated reports on the Child Protection Central Registry or that of other states in which the petitioner has resided since the last substantiated report of abuse, abandonment, or neglect in Idaho; and ( )

b. There are no convictions, adjudications, or withheld judgments for the following crimes on the state's central repository of criminal history records as established and maintained by the Idaho State Police under Title 67, Chapter 30, Idaho Code, or on the criminal history repository of other states in which the petitioner has resided since the last substantiated report of abuse, abandonment, or neglect in Idaho. It is the responsibility of the petitioner to request, pay for, and obtain these criminal history checks and submit them to the Department. ( )

i. The Department will not remove a petitioner from the Child Protection Central Registry if a criminal history check reveals any of the following, within five (5) years of the receipt of the petition: ( )

(1) Physical Assault; ( )

(2) Battery; or ( )

(3) A drug-related offense. ( )

ii. The Department will not remove a petitioner from the Child Protection Central Registry if a criminal history check reveals any of the following: ( )

(1) Child abuse or neglect; ( )

(2) Spousal abuse; ( )

(3) A crime against children, including child pornography; or ( )

(4) A crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery. ( )

02. Granting or Denying the Petition for Removal. The Department will issue a letter granting or denying removal of the petitioner's name from the Child Protection Central Registry within twenty-eight (28) days of receipt of the petition. ( )

03. Appeal of a Denial for Petition for Removal. The individual may file an appeal from the denial of removal of his name from the Child Protection Central Registry under IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings and Declaratory Rulings." ( )

04. Petition for Removal of Individuals on the Child Protection Central Registry Prior to October 1, 2007. After January 1, 2008, an individual whose name was placed on the Child Protection Central Registry prior to October 1, 2007, may file a petition to have his name removed from the registry in accordance with Subsection 564.01 of this rule. The petitioner will be assigned a child protection risk level in accordance with criteria under Section 563 of these rules and the case will be reviewed to see if it meets the requirements for removal. ( )

56~~2~~5. ~~*REGISTRY*~~ "SAFE HAVEN" EXEMPTION FOR PARENTS OF CERTAIN ABANDONED INFANTS.
No disposition will be made on the parent(s) and no information will be entered into the ~~*IDHW Central Registry*~~ Child Protection Central Registry when a parent(s) relinquishes their infant within the first thirty (30) days of life to a "Safe Haven" according to ~~*Section 39-8201*~~ Title 39, Chapter 82, Idaho Code, Idaho Safe Haven Act. ~~*(5-3-03)*~~( )

~~***563. UNSUBSTANTIATED REPORTS.***~~
~~*If it is determined through the risk assessment that a report is "unsubstantiated," the family shall also be advised. Upon the individual's request, the field office shall issue written statements indicating that:* (5-3-03)~~

~~***01. Insufficient Information**. The Department has not obtained sufficient information to warrant further assessment of or action on that specific report; and* (5-3-03)~~

~~***02. Further Reports**. The Department shall fulfill its legal responsibility to investigate*~~

~~*and take appropriate action on any further reports that elaborate on the previous allegations or relate new allegations.*~~ ~~*(5-3-03)*~~

56~~4~~6. COURT-ORDERED CHILD PROTECTION RISK ASSESSMENT.
When, in any divorce proceeding or upon request for modification of a divorce decree, an allegation of child abuse or child sexual abuse is made, implicating either party, the court ~~*shall*~~ may order that an investigation/risk assessment be conducted by the Department ~~*of Health and Welfare*~~. Court orders for preliminary child protective risk assessment and for any subsequent assessment the court may deem necessary ~~*shall*~~ will be served on the Department supervisor for child protection services in the field office in which the court has geographical jurisdiction. The child protection supervisor ~~*shall*~~ must immediately initiate the risk assessment and consult with the court promptly if there are any obstacles proceeding its completion. Immediately upon completing the report, the Department ~~*shall*~~ must make a written report to the court.
~~*(3-30-01)*~~(____)

56~~5~~7. PETITION UNDER THE CHILD PROTECTIVE ACT.
If any incidence of child abuse, abandonment, or neglect~~*, or abandonment*~~ is substantiated through an immediate safety or comprehensive assessment, or both, or during the provision of services, and cannot be resolved through informal processes or voluntary agreement that is adequate for protection of the child, the Department ~~*must*~~ will request the prosecuting attorney to file a Child Protective Act petition. ~~*(3-30-07)*~~(____)

56~~6~~8. COOPERATION WITH LAW ENFORCEMENT.
The Department ~~*must*~~ will cooperate with law enforcement personnel in their handling of criminal investigations and the filing of criminal proceedings. ~~*(3-30-07)*~~(____)

56~~7~~9. CHILD CUSTODY INVESTIGATIONS FOR THE DISTRICT COURT.
Where no other community resources are available and when ordered by the district courts, the Department will, for a fee of thirty-five dollars ($35) per hour, conduct immediate safety and comprehensive assessments and provide social information to assist the court in child custody actions, to assist the court to determine the most therapeutic placement for the child. (3-30-07)

01. Requests From Private Attorney. If a parent's attorney requests an immediate safety or comprehensive assessment, or both, and a report of findings regarding the fitness of a parent, the attorney must be advised that such service is provided on behalf of a child but not on behalf of a litigant, and that any such assessment and report would be provided to the court pursuant to a court order. (3-30-07)

02. Conduct of the Assessment. In conducting the assessment, the family services worker must explain to the family the purpose for which the information is being obtained. If the judge intends to treat the report as evidence, the family must be informed that any information they provide will be brought out at the court hearing. If the family refuses to give information to the family services worker, the Department has no authority to require cooperation. However, the judge may issue an order directing the family to provide information to the family services worker for the purpose of making a report to the court. (3-30-07)

03. Report to Court. The family services worker will provide a report only to the Magistrate judge who ordered the assessment, and must use the Department's format for the

assessment of need. The report must describe what was observed about the home conditions and the care of the child(ren). (3-30-07)

04. Department Clients. If the family is or has been a client of the Department, disclosure of information must comply with Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Protection of Department Records." (3-30-07)

5~~68~~70. -- 639. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.12 - RULES GOVERNING THE IDAHO CHILD CARE PROGRAM (ICCP)

DOCKET NO. 16-0612-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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.

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 3, 2007, Idaho Administrative Bulletin, Vol. 07-10, pages 467 through 494.

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:

This rulemaking will make necessary changes to the Idaho Child Care Program and will balance the additional expenditures with planned savings.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Genie Sue Weppner or Cheryl Bowers at (208) 334-5815.

DATED this 30th day of October, 2007.

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
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DEPARTMENT OF HEALTH AND WELFARE ***Docket No. 16-0612-0701***
Rules Governing the Idaho Child Care Program (ICCP) ***PENDING RULE***

THE FOLLOWING NOTICE 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, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule making:

This rule change will incorporate recommendations obtained from the Office of Performance Evaluation (OPE), Legislative Auditors, higher education stakeholders, advocacy group stakeholders, Health and Welfare Committees of the House and the Senate, and the Idaho Childcare Advisory Panel to:

1. **Increase the current income limits to 135% of the 2007 Federal Poverty Guidelines.**
2. **Update the co-payment rates to more accurately reflect the smaller income increases typical of families receiving ICCP.**
3. **Allow post-secondary education as an eligible activity for four years (40 months).**

The current chapter of ICCP rules will be revised in order to add or update required sections; eliminate redundant sections of rules; update, revise, clarify and reorganize chapter content. Idaho's citizens will be able to locate and understand sections of the rule that they are most interested in.

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

There are no new fees, charges, or increases that are being imposed in this rulemaking.

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.

This rulemaking will make necessary changes to the Idaho Child Care Program and will balance the additional expenditures with planned savings.

NEGOTIATED RULEMAKING: Several negotiated rulemaking meetings were conducted in

2007 in Boise with a committee appointed by the 2007 Legislature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Genie Sue Weppner or Cheryl Bowers at (208) 334-5815.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 24, 2007.

DATED this 20th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
~~*The Idaho Department of Health and Welfare, according to Sections 56-201 through 56-233, Idaho Code, is authorized to adopt the following rules for the administration of public assistance programs.*~~ Under Section 56-202, Idaho Code, the Director of the Department of Health and Welfare is authorized to promulgate, adopt, and enforce rules for the administration of public assistance programs. ~~*(7-1-99)*~~( )

001. TITLE AND SCOPE.

01. Title. ~~*These rules are known and will be cited as*~~ The title of this chapter of rules is IDAPA 16.06.12, "Rules Governing the Idaho Child Care Program (ICCP)." ~~*(7-1-99)*~~( )

02. Scope. These rules provide ~~*standards*~~ the requirements for determining participant and provider eligibility for the Idaho Child Care Program (ICCP) and issuing child care benefit payments. ~~*(7-1-99)*~~( )

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for these rules. (7-1-99)

003. ADMINISTRATIVE APPEALS.

01. Administrative Appeals. All administrative ~~*A*~~appeals are governed by ~~*Idaho Department of Health and Welfare Rules,*~~ provisions of IDAPA 16.05.03, ~~*Section 300, et seq.,*~~ "Rules Governing Contested Cases Proceedings and Declaratory Rulings." ~~*(7-1-99)*~~( )

02. Complaint Procedure. The Department will maintain a record of substantiated child protection complaints against child care providers. Information regarding such substantiated child protection complaints is available in accordance with the Section 006 of these rules. ( )

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference in this chapter of rules. ( )

~~***005. ABBREVIATIONS.***~~
~~*The following abbreviations apply to this chapter:* *(7-1-99)*~~

~~***01. GED**. General Equivalency Diploma.* *(7-1-99)*~~

~~***02. ICCP**. Idaho Child Care Program.* *(7-1-99)*~~

~~***03. PRC**. Personal Responsibility Contract.* *(7-1-99)*~~

~~***04. SSI**. Supplemental Security Income.* *(7-1-99)*~~

~~***05. TAFI**. Temporary Assistance for Families in Idaho.* *(7-1-99)*~~

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEB SITE.

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 Web Site. The Department's internet web site is found at http://www.healthandwelfare.idaho.gov. ( )

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.
Any use or disclosure of Department records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

007. -- 009. (RESERVED).

~~*004*~~ 010. DEFINITIONS AND ABBREVIATIONS -- A THROUGH L.
The following definitions and abbreviations apply to this chapter: ~~*(7-1-99)*~~( )

01. ~~***Caretaker**. The person responsible for the care of a child.*~~ AABD. Aid to the Aged, Blind, and Disabled. ~~*(7-1-99)*~~( )

02. Child. Any person under age eighteen (18) under the care of a parent, or a person eighteen (18) years of age or older who is claimed on tax returns as a dependent. ( )

0~~2~~3. Child ~~*Day*~~ Care. Care, control, supervision, or maintenance of a child provided for compensation by an individual, other than a parent, for less than twenty-four (24) hours in a day. ~~*(5-3-03)*~~(____)

~~***03. Child Support Income**. Any payment made by an absent parent designated to be used for the children.*~~ ~~*(7-1-99)*~~

~~***04. Child(ren)**. All children under eighteen (18), if they are related to the parent or caretaker as specified above. Children over eighteen (18) or older, if claimed on tax returns as a dependent by the child's caretaker relative or parent.*~~ ~~*(7-1-99)*~~

0~~5~~4. Department. The Idaho Department of Health and Welfare. (7-1-99)

0~~6~~5. Earned Income. ~~*Gross i*~~Income received by a person as wages, tips, or self-employment income before deductions for taxes or any other purposes. ~~*(7-1-99)*~~(____)

0~~7~~6. Employment. A job paying wages or salary at federal or state minimum wage, whichever is applicable, including work paid by commission or in-kind compensation. Full or part-time participation in a VISTA or AmeriCorps program is also ~~*considered*~~ employment. ~~*(7-1-99)*~~(____)

0~~8~~7. Foster Care. The twenty-four (24) hour substitute care of children provided in a foster home by persons who may or may not be related to a child. Foster care is provided in lieu of parental care ~~*provided for a child by a family,*~~ and is arranged through a private or public agency. ~~*(7-1-99)*~~(____)

0~~9~~8. Foster Child. A child placed for twenty-four (24) hour substitute care by a private or public agency. ~~*(7-1-99)*~~(____)

09. Foster Home. The private home of an individual or family licensed or approved as meeting the standards for foster care and providing twenty-four (24) hour substitute care to six (6) or fewer children. (____)

~~**10. *Fraud**. Obtaining or attempting to obtain ICCP services for which one is not eligible or in an amount to which not entitled by means of a willfully false statement or representation, or other fraudulent device.*~~ ~~*(7-1-99)*~~

1~~1~~0. Good Cause. The conduct of a reasonably prudent person in the same or similar circumstances, unless otherwise defined in these rules. (7-1-99)

1~~2~~1. In Loco Parentis. Acting "in loco parentis" means a person who acts in place of a parent, assuming care and custody of a child by ~~*an individual not related to the child*~~ a formal or informal agreement with the child's parent. ~~*(7-1-99)*~~(____)

1~~3~~2. Job Training and Education Program. A program ~~*recognized as a*~~ designed to provide job training or education ~~*program*~~. Programs may include high school, junior college, community college, college or university, general equivalency diploma (GED), technical school,

and vocational programs. To qualify as a Job Training and Education Program, the program must prepare the trainee for employment. ~~(7-1-99)~~(____)

13. Licensed Practitioner of the Healing Arts. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. (____)

~~***14. Loan**. Debt having a signed repayment agreement.* (7-1-99)~~

~~***15. Local Market Rate for Child Care**. Payment of child care set at the seventy-fifth percentile of the range of costs for child care in a specific area. The rate is adjusted for the age of the child, the region, and the type of child care facility. The local market rate establishes the maximum amount payable by ICCP.* (7-1-99)~~

~~***16. Mediation**. Process to resolve disputes between providers of child care services and parents or caretakers of children receiving child care.* (7-1-99)~~

011. DEFINITIONS AND ABBREVIATIONS -- M THROUGH Z.
The following definitions and abbreviations apply to this chapter of rules: (____)

~~17~~01. Minor Parent. ~~P~~A parent under the age of eighteen (18). ~~*The minor parent is not considered a child for the purpose of determining eligibility for child care assistance.*~~ ~~(7-1-99)~~(____)

~~***18. Related Caretaker**. An adult caretaker, other than a parent, related to the child by blood or marriage. This includes grandparents, great-grandparents, brothers, sisters, aunts, uncles, nephews, nieces, or first cousins. Relatives by marriage also include step-siblings.* (5-3-03)~~

~~19~~02. Non-Recurring Lump Sum Income. Income received by a family in a single payment, not expected to be available to the family again. (7-1-99)

~~***20. Non-Related Caretaker**. A person who is not related to an eligible child, who is acting in loco parentis.* (7-1-99)~~

~~21~~03. Parent ~~or Guardian~~. ~~P~~A person~~s legally~~ responsible for a child~~(ren)~~ because of birth, adoption, step-parent, or ~~*legal*~~ guardianship; or a person acting in loco parentis. ~~(7-1-99)~~(____)

~~2~~04. Preventive Services. Services needed to reduce or eliminate the need for protective intervention. Preventive services permit families to participate in activities designed to reduce or eliminate the need for out-of-home placement of a child by the Department. ~~(5-3-03)~~(____)

~~22~~05. Prospective Income. Income a family expects to receive within a given time. This can be earned or unearned income. (7-1-99)

~~23~~06. Provider. An individual, organization, agency, or other entity providing child care. (7-1-99)

07. **Relative Provider**. Grandparent, great-grandparent, aunt, uncle, or adult sibling by blood or current marriage who provides child care. ( )

08. **SSI**. Supplemental Security Income. ( )

~~***25.*** ***Resources****. Money or items that can be converted to money that can be used for family care.* *(7-1-99)*~~

~~***26.*** ***Satisfactory Progress****. A standard of progress which a participant must meet in an educational or training program. Standards are established by each individual program and must include both qualitative and quantitative measures of progress.* *(7-1-99)*~~

~~***27***~~**09.** **Special Needs**. Any child with physical, mental, emotional, behavioral disabilities, or developmental delays identified on an Individual Education Plan (IEP) or an Individualized Family Service Plan (IFSP). ~~*(5-3-03)*~~( )

10. **TAFI**. Temporary Assistance for Families in Idaho. ( )

~~***28.*** ***Step-Parent****. A person married to the child's parent who has no biological or adoptive relationship to the child.* *(7-1-99)*~~

~~***29***~~**11.** **Unearned Income**. ~~*Income other than employment or self-employment.*~~ Unearned income includes retirement ~~*and*~~, interest child support, and any income received from a source other than employment or self-employment.. ~~*Money received when a resource is liquidated is unearned income during the month in which it is received.* *(5-3-03)*~~( )

~~***30.*** ***Unmarried Parents****. Individuals not married to each other, but whose common child lives in the home.* *(5-3-03)*~~

~~***31.*** ***Very Low Income****. Family income less than one hundred fifty percent (150%) of the Federal Poverty Limit.* *(5-3-03)*~~

~~***32.*** ***Working****. An individual is considered working when he has a job paying wages or salary, including work paying commission or in-kind compensation.* *(5-3-03)*~~

~~***006. 049. (RESERVED).***~~

~~***050. APPLICATION.***~~
~~*A written application must be completed and signed by the caretaker and received by the Department. The date of the application is the date received by the Department. The caretaker shall be notified, in writing, of the approval or denial of the application and the right to appeal, if applicable.* *(7-1-99)*~~

~~***051. EFFECTIVE DATE.***~~
~~*An eligible caretaker shall receive child care payments from the first day of the month of application.* *(7-1-99)*~~

~~***052. – 056. (RESERVED).***~~

~~***057. PARENTAL CHOICE.***~~
~~*Eligible parents or caretakers may choose among all types of available child care.* *(7-1-99)*~~

0~~*58*~~12~~*. – 099.*~~ ~~*(RESERVED).*~~

THE APPLICATION AND ELIGIBILITY DETERMINATION PROCESS

(Sections 100 through 199)

100. ~~*ELIGIBILITY FOR CHILD CARE ASSISTANCE*~~ APPLICATION AND INCOME LIMITS FOR CHILD CARE BENEFITS.
~~*Families must meet the following conditions of eligibility and provide verification requested by the Department before child care assistance is provided.*~~ Child care benefits are payments from the Department to child care providers on behalf of eligible families. An application for assistance for child care benefits must be completed, signed by the applicant, and received by the Department. The date of the application is the date it is received by the Department. The applicant must be notified in writing of the approval or denial of the application and of the right to appeal, if applicable. In order to receive ICCP assistance the applicant must not exceed the gross income limits described in Subsections 100.01 and 100.02 of this rule: ~~*(7-1-99)*~~( )

01. Maximum Income Limits for ICCP Benefits. The maximum income limit for eligibility for payment of ICCP benefits is based on one hundred thirty-five percent (135%) of the 2007 federal poverty guidelines. Maximum income limits by family size are as follows: ( )

a. One thousand five hundred forty dollars ($1,540) for a household of two (2); ( )

b. One thousand nine hundred thirty-two dollars ($1,932) for a household of three (3); ( )

c. Two thousand three hundred twenty-three dollars ($2,323) for a household of four (4); ( )

d. Two thousand seven hundred fifteen dollars ($2,715) for a household of five (5); ( )

e. Three thousand one hundred six dollars ($3,106) for a household of six (6); ( )

f. Three thousand four hundred ninety-eight dollars ($3,498) for a household of seven (7); ( )

g. Three thousand eight hundred eighty-nine dollars ($3,889) for a household of eight (8); ( )

h. Four thousand two hundred eighty-one dollars ($4,281) for a household of nine: and ( )

i. Four thousand six hundred seventy-two dollars ($4,672) for a household of 10. ( )

02. Additional Household Member. Three hundred ninety-two dollars ($392) is added to the maximum income limit for each additional family member. ( )

101. ~~*RESIDENCY*~~ PARENTAL CHOICE OF CHILD CARE PROVIDER.
~~*The family must live in the state of Idaho, and have no immediate intention of leaving.*~~ Eligible parents may choose among the following types of child care providers available under ICCP: ~~*(7-1-99)*~~( )

01. Child Care Center. A child care center cares for thirteen (13) or more children. ( )

02. Group Child Care. Group child care is for seven (7) to twelve (12) children. ( )

03. Family Child Care. Family child care is for six (6) or fewer children. ( )

04. Relative Child Care. Relative child care is for six (6) or fewer related children. ( )

05. In-Home Child Care. In-home child care is provided by a relative or non-relative in the home of the child. Eligibility for in-home child care is determined in accordance with Section 400 of these rules. ( )

102. ~~*CITIZENSHIP AND ALIENAGE*~~ RESIDENCY.
~~*At least one (1) child must meet the citizenship and alienage requirements for the family to be eligible for child care assistance. Any child eligible for payment must be a citizen or an alien admitted to the United States for permanent residence, or lawfully living in the United States.*~~ The family must live in the state of Idaho, and have no immediate intention of leaving. ~~*(7-1-99)*~~( )

103. (RESERVED).

104. FAMILY COMPOSITION.
A family is a group of individuals living in a common residence, whose combined income is considered in determining eligibility and ~~*payment*~~ the child care benefit amount. ~~*Each individual meeting the family criteria in Subsections 104.01 through 104.06 of these rules must be included in the family size. No individual may be considered a member of more than one (1) family in the same month.*~~ No individual may be considered a member of more than one (1) family in the same month. The following individuals are included in determining the family composition: ~~*(5-3-03)*~~( )

01. Married ~~*Spouses*~~ Parents. Married ~~*spouses*~~ parents living together in a common

residence ~~are considered a family~~. ~~(5-3-03)~~(____)

02. Unmarried Parents. Unmarried parents ~~living together in a common residence are considered a family~~ who live in the same home and who have a child in common living with them. ~~(5-3-03)~~ (____)

03. ~~Tax~~ Dependents. Individuals who are claimed as ~~tax~~ dependents~~, living in the home, are considered members of the family~~ for tax purposes. ~~(5-3-03)~~(____)

04. Minor Parent. A minor parent and child are considered a separate family when they apply for ~~ICCP~~ child care benefits, even if they live with other relatives. ~~(5-3-03)~~(____)

05. ~~Non-Related Caretaker~~. ~~*When parents make a formal or informal agreement for another individual to care for their child, the non-related caretaker is eligible to apply for benefits. The caretaker must meet all eligibility requirements.*~~ **Individual Acting In Loco Parentis**. An individual acting in loco parentis who is eligible to apply for child care benefits. ~~(5-3-03)~~(____)

~~**06. Adult Relatives**. *Adult relatives who are not parents of a common child, who reside together are considered separate families. Unrelated families living in a common residence are considered separate families.* (5-3-03)~~

105. ELIGIBLE CHILD.
~~*A family must have at least one (1) eligible child. A child is eligible under the conditions listed in Subsections 105.01 through 105.04.*~~ A family can only receive child care benefits for eligible children. A child is eligible for child care benefits under the following conditions: ~~(7-1-99)~~(____)

01. Immunizations Requirements. ~~*Eligible pre-school children must obtain immunizations according to the Department's schedule of immunizations, unless there is a religious or other exemption, or immunization would endanger the life or health of a child. Child care payments can continue during a reasonable period necessary to comply with immunization standards. Immunization records must be reviewed annually.*~~ A child must be immunized in accordance with IDAPA 16.02.11, "Immunization Requirements for Children Attending Licensed Day Care Facilities in Idaho." Child care benefits can continue during a reasonable period necessary for the child to be immunized. Parents must provide evidence that the child has been immunized unless the child is attending school. ~~(7-1-99)~~(____)

02. ~~Under Age Thirteen~~. ~~*A child whose care is being paid must be under the age of thirteen (13); or*~~ **Citizenship or Alien Status Requirement**. A child must be one (1) of the following: ~~(7-1-99)~~(____)

a. A citizen; (____)

b. Living lawfully in the United States. (____)

03. ~~Age Thirteen Through Eighteen~~. ~~*A child age thirteen (13) or older must meet one (1) of the criteria listed in Subsections 105.03.a. through 105.03.b.*~~ **Child's Age Requirement**. A child must be under thirteen (13) years of age, with the following exceptions: ~~(7-1-99)~~(____)

a. ~~*Children may receive child care benefits until the month of their eighteenth birthday if they are physically or mentally incapable of self-care, as verified by a professional third party.*~~ A child thirteen (13) years of age or older may be eligible for child care benefits if he meets one (1) or more of the following criteria: ~~*(7-1-99)*~~(____)

i. A child is eligible for child care benefits until the month of his eighteenth birthday if he is physically or mentally incapable of self-care, as verified by a licensed mental health professional or licensed practitioner of the healing arts. (____)

ii. A child may be eligible for child care benefits until the month of his eighteenth birthday if a court order, probation order, child protection, or mental health case plan requires constant supervision. (____)

b. ~~*Children may receive child care benefits until the month of their eighteenth birthday if a court order, probation contract, child protection or mental health case plan requires constant supervision.*~~ A child who is eligible under Subsection 105.03.a. may receive child care benefits until the month of his nineteenth birthday if he is a full-time student and is expected to complete secondary school no later than the month of his nineteenth birthday. ~~*(7-1-99)*~~(____)

~~***04. Age Eighteen and Over****. Children who qualify under Subsection 106.03 may receive child care benefits until the month of their nineteenth birthday if they are full-time students and are expected to complete secondary school no later than the month of their nineteenth birthday.*~~ ~~*(7-1-99)*~~

~~***106. 107. (RESERVED).***~~

106. INCAPACITATED PARENT.
An incapacitated parent, unable to adequately care for the children in a two (2) parent family, is not required to have any qualifying activities as listed under Section 200 of these rules, as long as the other parent is participating in qualifying activities. A single parent family in which the parent is incapacitated is not eligible for ICCP. A parent with a disability does not automatically qualify as an incapacitated parent. (____)

~~***108. QUALIFYING ACTIVITIES FOR CHILD CARE.***~~
~~*To be eligible for child care payments, a parent must need child care for one (1) of the following reasons:*~~ ~~*(4-11-06)*~~

~~***01. Child Care Needed for Employment****. The parent must need child care to seek, accept, or maintain employment.*~~ ~~*(4-11-06)*~~

~~***a.*** *An unemployed parent can use the search for work as the activity qualifying them for child care assistance for a total of no more than three (3) months during a calendar year. However, when work search activities are required by the Department, the parent is not subject to this three (3) month limit.*~~ ~~*(4-11-06)*~~

~~***b.*** *For any of these three (3) months in which the parent claims to be looking for work, eighty (80) hours of work search will be counted as the qualifying activity for child*~~

~~care.These activity hours are used as a factor in determining the amount of child care assistance.The actual amount of payment is based on Section 305 of these rules. (4-11-06)~~

~~**c.** When work search is the qualifying activity, it can not be combined with any other qualifying activity listed under Section 108 of these rules. (4-11-06)~~

~~**02. Child Care Needed for Training or Education**. The parent must need child care to attend an education or training program. Persons with baccalaureate degrees or who are attending post-baccalaureate classes do not qualify for child care assistance. Satisfactory progress in the program must be maintained in order to continue to receive benefits. (4-11-06)~~

~~**03. Child Care Needed for Preventive Services**. The parent must need child care to access preventive services. Preventive services permit families to participate in treatment services designed to reduce or eliminate the need for out-of-home placement of a child by the Department. The Department must verify the continued need for preventive services at least every three (3) months. (4-11-06)~~

~~**04. Activities Negotiated Between the Department and Parent**. The parent must need child care to complete Personal Responsibility Contract activities negotiated between the Department and the parent. (4-11-06)~~

~~**109. INCAPACITATED PARENT.**~~
~~An incapacitated parent, unable to adequately care for the children in a two (2) parent family, is not required to have qualifying activities, as long as the other parent is participating in qualifying activities. (7-1-99)~~

~~**110. INTERIM CHILD CARE PAYMENT.**~~
~~If child care arrangements would otherwise be lost, child care may be paid under conditions listed in Subsections 110.01 and 110.02. Relative providers are not eligible for interim child care payments. (5-3-03)~~

~~**01. Employment to Begin**. If employment or education is scheduled to begin within two (2) weeks. (7-1-99)~~

~~**02. Break in Employment**. During a break in employment or education of one (1) month or less. (7-1-99)~~

1~~11~~07. -- 199. (RESERVED).

QUALIFYING ACTIVITIES AND REPORTING REQUIREMENTS

(Sections 200 through 299)

200. ~~INCOME LIMIT~~ QUALIFYING ACTIVITIES FOR CHILD CARE BENEFITS.
~~A family's income must be less than the published OMB guidelines for one hundred fifty percent~~

~~(150%) of poverty for a family of the same size.~~ To be eligible for child care benefits, a family must need child care because they are engaged in one (1) of the following activities that qualifies them for child care benefits: ~~(7-1-99)~~(____)

01. **Employment**. The parent is currently employed. (____)

02. **Training or Education**. The parent is attending an accredited education or training program. The following restrictions apply to training or education activities: (____)

a. On-line classes cannot be counted as a qualifying activity for child care. (____)

b. Persons with baccalaureate degrees or who are attending post-baccalaureate classes do not qualify for child care benefits. (____)

c. More than forty (40) months of post-secondary education has been used as a qualifying activity. (____)

03. **Preventive Services**. The parent is receiving preventive services as defined in Section 011 of these rules. The Department will verify the continued need for preventive services at least every three (3) months. (____)

04. **Personal Responsibility Contract (PRC)**. The parent is completing Personal Responsibility Contract (PRC) activities negotiated between the Department and the parent as described in IDAPA 16.03.08, "Rules Governing Temporary Assistance for Families (TAFI) in Idaho." (____)

201. ~~***COUNTABLE INCOME***~~ **REPORTING REQUIREMENTS FOR FAMILIES.**
~~*All gross earned and unearned income is counted in determining eligibility and payment amount, unless specifically excluded by rule.*~~ ~~*(7-1-99)*~~

01. **Changes That Must Be Reported Within Ten Days**. A family who applies for or receives child care benefits must report the following changes within ten (10) days of the change: (____)

a. Anyone entering or leaving the household. (____)

b. Change in the rates charged for child care services; (____)

c. Change in the hours or nature of any qualifying activity; (____)

d. Change in the number of hours worked; (____)

e. A permanent change in rate of pay; (____)

f. Any other permanent change in monthly income, either earned or unearned; and (____)

g. A change of address for either the participant or the child care provider. (____)

02. Changing Providers. ( )

a. Changing Providers During the Month. A parent must notify ICCP by the twenty-fifth of the month of his intent to change providers for the next month of service. ( )

b. Changing Providers Without Providing Notice. A parent who chooses to change providers without providing notice to the Department and who does not have good cause for failing to report the change, is responsible to pay the new provider for the next month of service. ( )

~~***202. EXCLUDED INCOME.***~~
~~*The following is not counted as family income.* (7-1-99)~~

~~***01. Earned Income of a Dependent Child**. Income earned by a dependent child under age eighteen (18) is not counted unless the child is a parent.* (7-1-99)~~

~~***02. Income Received for Person Not Residing With the Family**. Income received on behalf of a person not living in the home is excluded.* (7-1-99)~~

~~***03. Education Funds**. All educational funds including grants, scholarships, an Americorps Education Award, and federal and state work study income.* (7-1-99)~~

~~***04. Assistance**. Assistance to meet a specific need from other organizations and agencies is not counted as income.* (7-1-99)~~

~~***05. Lump Sum Income**. Non-recurring or lump-sum income is excluded as income if used to pay medical bills resulting from accident or injury, or used to pay funeral or burial costs. When lump-sum income, minus exclusions, exceeds the maximum income listed in the Sliding Fee Schedule, the family is not eligible to receive benefits. The period of ineligibility is computed by dividing the lump-sum payment into the maximum qualifying income for that family. In no case will the period of ineligibility exceed twelve (12) months.* (5-3-03)~~

~~***06. Loans**. Loans with written, signed repayment agreements are not counted as income.* (7-1-99)~~

~~***07. TAFI and AABD Benefits**. TAFI and AABD benefits are excluded.* (7-1-99)~~

~~***08. Foster Care Payments**. Foster care payments are excluded as income.* (7-1-99)~~

~~***09. VISTA Volunteers**. Living allowances and stipends paid to VISTA volunteers under P.L. 93-113, Title IV, Section 404(g) are excluded as income.* (7-1-99)~~

~~***10. Income Tax Refunds/Earned Income Tax Credits**. Income tax refunds and earned income tax credits even if received with their wages are excluded as income.* (7-1-99)~~

~~***11. Travel Reimbursements**. Reimbursements from employers for work related travel are excluded from income.* (7-1-99)~~

~~**12. Tribal Income**. Income received from a tribe for any purpose other than direct wages are excluded from income. (7-1-99)~~

~~**13. Foster Parents Income**. Income may be excluded based on need, on a case by case basis, for foster parents when determining eligibility and sliding fee scale amounts for children in the custody of the Department. Income is counted when determining eligibility and sliding fee scale amounts for the foster parent's biological child(ren). (7-1-99)~~

~~**14. Adoption Assistance**. Adoption assistance payments are excluded from income. (5-3-03)~~

~~**15. Child Support Payments**. Court ordered child support payments made by the participant are excluded from income. Both the legal obligation to pay child support and the actual amount paid must be verified. (7-1-99)~~

~~**203. SELF-EMPLOYMENT INCOME.**~~
~~Income from self-employment is earned income. The family may choose one (1) of the calculation methods in Subsections 203.01 and 203.02 of these rules to determine income. Annualize the income if the participant has been self-employed for more than one (1) year. Average the income over the period of time the business has been operating, if the participant has been self-employed for less than one (1) year. (5-3-03)~~

~~**01. Gross Self-Employment Income**. Gross self-employment income, less fifty percent (50%) for business expenses, is counted as family income. If the participant's current income from his business is different than past income, anticipate self-employment income and expenses. (5-3-03)~~

~~**02. Net Self-Employment Income**. Net self-employment income is calculated from gross income. Subtract these allowable expenses: (5-3-03)~~

~~**a.** The cost of labor paid to individuals not in the home. (5-3-03)~~

~~**b.** The cost of business inventory. (5-3-03)~~

~~**c.** The cost of material. (5-3-03)~~

~~**d.** The cost for rent and utilities, advertising, shipping and legal fees. (5-3-03)~~

~~**e.** The cost of seed and fertilizer. (5-3-03)~~

~~**f.** Interest paid to purchase income-producing property, including real estate. (5-3-03)~~

~~**g.** Insurance premiums. (5-3-03)~~

~~**h.** Taxes paid on income-producing property. (5-3-03)~~

~~*i.* *Transportation, when a vehicle is an integral part of business activity.* (5-3-03)~~

~~***204. – 249. (RESERVED).***~~

~~***250. CHILD CARE PROVIDER LICENSING.***~~
~~*All providers of child care receiving a Department subsidy must be licensed or must comply with applicable State Day Care licensing requirements under Title 39, Chapter 11, Idaho Code, with local licensing ordinances, or with tribal ordinances. If both state statutes and ordinances apply to a provider, the provider must comply with the stricter requirement. A provider operating outside Idaho must comply with the licensing laws of his state or locality.* (7-1-99)~~

~~***251. HEALTH AND SAFETY REQUIREMENTS.***~~
~~*All providers must submit a written statement that they comply with the health and safety requirements listed in Subsections 251.01 through 251.10 of these rules. The provider must agree to a health and safety inspection. Compliance with these standards does not exempt a provider from complying with stricter health and safety standards under state law, tribal law, local ordinance, or other applicable law.* (5-3-03)~~

~~***01. Age of Provider****. All child care providers providing services must be eighteen (18) years old or older. Persons sixteen (16) or seventeen (17) years old may provide child care if they have direct, on-site supervision from a licensed child care provider who is at least eighteen (18) years old.* (7-1-99)~~

~~***02. Sanitary Food Preparation****. Food for use in child care facilities must be prepared and served in a sanitary manner. Utensils and food preparation surfaces must be cleaned and sanitized before using to prevent contamination.* (7-1-99)~~

~~***03. Food Storage****. All food served in child care facilities must be stored to protect it from potential contamination.* (7-1-99)~~

~~***04. Hazardous Substances****. Medicines, cleaning supplies, and other hazardous substances must be stored out of the reach of children.* (7-1-99)~~

~~***05. Emergency Communication****. A telephone or some type of emergency communication system is required.* (7-1-99)~~

~~***06. Smoke Detectors, Fire Extinguisher and Exits****. A properly installed and operational smoke detector must be on the premises where child care occurs. Adequate fire extinguishers and fire exits must be available on the premises.* (7-1-99)~~

~~***07. Hand Washing****. Each provider shall wash his hands with soap and water at regular intervals, including before feeding, after diapering or assisting children with toileting, after nose wiping, and after administering first aid.* (7-1-99)~~

~~***08. CPR/First Aid****. Providers shall insure that at all times children are present at least one (1) adult on the premises has current certification in pediatric rescue breathing and first aid treatment from a certified instructor.* (7-1-99)~~

~~**09. Health of Provider**. Each provider shall certify that he/she does not have any physical or psychological condition that might pose a threat to the safety of a child in his/her care. (7-1-99)~~

~~**10. Child Abuse**. Providers must report suspected child abuse to the appropriate authority. (7-1-99)~~

~~**252. CHILD CARE PROVIDER AGREEMENT.**~~
~~All providers shall sign and comply with a Provider Agreement made with the Department. (5-3-03)~~

~~**253. – 254. (RESERVED).**~~

~~**255. CONVICTION OR WITHHELD JUDGMENT.**~~
~~Child care providers must certify that they have not been convicted or received a withheld judgment, for any of the following crimes: homicide, kidnaping, arson, assault and battery, or sexual abuse of a child. A self-declaration must be signed by each provider, attesting he has not been convicted or received a withheld judgment for any of the above listed crimes, including the following: a sex crime as defined in Chapter 66, Title 18, Idaho Code, or any similar provision in another jurisdiction; rape as defined in Chapter 61, Title 18, Idaho Code, or any similar provision in another jurisdiction; injuring a child as defined in Section 18-1501, Idaho Code, or any similar provision in another jurisdiction; selling or bartering a child as defined in Section 18-1511, Idaho Code, or any similar provision in another jurisdiction; sexually abusing a child as defined in Section 18-1506, Idaho Code, or any similar provision in another jurisdiction; sexually exploiting a child as defined in Section 18-1507, Idaho Code, or any similar provision in another jurisdiction. (7-1-99)~~

~~**256. PURVIEW OF CHILD PROTECTION ACT OR JUVENILE JUSTICE REFORM ACT.**~~
~~Providers must certify that they are not, through stipulation or adjudication, under the purview of the Child Protection Act, Section 16-1600, Idaho Code, or the Juvenile Corrections Act, Section 20-501 through 20-547, Idaho Code. Any provider who has an adjudicated valid child protection complaint cannot be an eligible provider. (7-1-99)~~

~~**257. PARENT OR CARETAKER ACCESS TO CHILD CARE PREMISES.**~~
~~Providers serving families who receive a child care subsidy shall allow parents or caretakers unlimited access to their children and to persons giving care, except that access to children will not be required if prohibited by court order. (7-1-99)~~

~~**258. – 269. (RESERVED).**~~

~~**270. ALLOWABLE CHILD CARE COSTS.**~~
~~Care provided to an eligible child by an eligible provider is payable subject to the following conditions: (7-1-99)~~

~~**01. Payment for Employment, Seeking Employment, Training, Education, or Preventive Service Hours**. Child care must be reasonably related to the hours of the qualifying activities. Travel time is included in determining qualifying activities. (7-1-99)~~

~~***02. Family Member or Guardian Not Payable**. A parent, step-parent, or unmarried parent must not be paid for providing child care to his child. A guardian must not be paid for providing child care for a child for whom he has guardianship. (5-3-03)***~~

~~***03. Provider Living at Same Address**. Child care by a child's grandparent, great-grandparent, aunt, uncle, or adult sibling living at the same address as the family will not be paid unless a condition in Subsections 270.03.a. through 270.03.c. of these rules is met. (5-3-03)***~~

~~***a.** The parents' or caretakers' qualifying activity occurs when out-of-home care is not available. (5-3-03)***~~

~~***b.** The family lives in an area where out-of-home care is not available. (5-3-03)***~~

~~***c.** A child has a verified illness or disability. The illness or disability would place the child at risk in an out-of-home facility, or place the other children in the facility at risk. (5-3-03)***~~

~~***04. One-Time Registration Fees**. One-time fees for registering a child in a child care facility are payable, if the fee is charged to all who enroll in the facility. Fees may not exceed usual and customary rates charged to all families. Registration fees are separate from local market rates. (5-3-03)***~~

~~***271. REPORTING REQUIREMENTS FOR FAMILIES.***~~
~~*Families applying for or receiving child care benefits shall report within ten (10) days the changes listed in Subsections 271.01 through 271.05 of these rules. (5-3-03)*~~

~~***01. Provider Charges**. The rates charged for child care services changes. (7-1-99)***~~

~~***02. Provider**. A child stops attending a child care, or is taken to another child care provider. (5-3-03)***~~

~~***03. Activity**. Hours or nature of qualifying activity changes. (5-3-03)***~~

~~***04. Income**. The number of hours worked or a permanent change in rate of pay. Any permanent change in monthly income of twenty-five dollars ($25) or more. (5-3-03)***~~

~~***05. Change of Address**. There is a change of address for either the participant or the provider. (7-1-99)***~~

~~***272. REPORTING REQUIREMENTS FOR PROVIDERS.***~~
~~*Child care providers shall report within ten (10) days the changes listed in Subsections 272.01 through 272.05 of these rules. (5-3-03)*~~

~~***01. Change in Provider Charges**. The provider changes the rates for child care services. (5-3-03)***~~

~~***02. Child Stops Attending Care**. A child stops attending child care, or is taken to another child care provider. (5-3-03)***~~

~~***03. Change of Provider Address**. There is a change in the location where child care is provided. (5-3-03)***~~

~~***04. Change in Who Lives in Home**. Individuals providing child care in their home must report when someone moves into the home. (5-3-03)***~~

~~***05. Intent Not to Renew License**. The provider intends to not renew his license, or other required certifications. (5-3-03)***~~

2~~73~~02. -- 299. (RESERVED).

FINANCIAL CRITERIA FOR ICCP ELIGIBILITY

(Sections 300 through 399)

300. ~~CALCULATING A FULL MONTH'S INCOME USING ACTUAL AND PROJECTED~~ INCOME LIMIT.

~~*Calculate the monthly income using actual income already received during the month and income expected to be received in the month. The household and the Department must agree this is a reasonable estimate of that month's income.*~~ A family's income must be less than the published 2007 federal poverty guidelines for one hundred thirty-five percent (135%) of poverty for a family of the same size. The federal poverty guidelines are available on the U.S. Health and Human Services web site at http://aspe.hhs.gov/poverty/index.shtml. ~~*(5-3-03)*~~( )

~~***01. Full Month's Income Expected from an Ongoing Source**. If no changes are expected, use the actual income received in the past thirty (30) days to project a full month's income. If changes are expected, project the income for the month with the new information. (5-3-03)***~~

~~***02. Full Month's Income Not Expected from an Ongoing Source**. If a full month's income is not expected from an ongoing source, count the income expected for the month. If the actual amount is known, use the actual income. If the actual income is unknown, project the expected income for that month. (5-3-03)***~~

~~***03. Full Month's Income Not Expected from a New Source**. If income is from a new source and a full month's income is not expected, count the actual income expected for the month. Do not convert the new source of income to a monthly amount. If the actual income is unknown, project the expected income for that month. (5-3-03)***~~

~~***04. Income from Terminated Source**. If income is from a terminated source, and no additional income is expected in a future month, count the actual income received during the month. Do not convert income to a monthly amount if a full month's income from the terminated source is not expected. (5-3-03)***~~

~~***05. Seasonal Income**. If income changes seasonally, consider the household's income from the last season and any pay changes to project the month's income. (5-3-03)***~~

~~***06. Fluctuating Income**. When income fluctuates each pay period and the rate of pay remains the same, average the income from the past thirty (30) days to determine the average pay period amount. Convert the average pay period amount to a full month's income. (5-3-03)***~~

~~***07. Income Paid as Salary**. Count income paid as salary at the expected monthly salary rate. Do not count salary at an hourly rate. (5-3-03)***~~

301. ~~*(RESERVED)*~~ COUNTABLE INCOME.
All gross earned and unearned income is counted in determining eligibility and the child care benefit amount, unless specifically excluded under Section 302 of these rules. If a self-employed individual has no countable income for a period of three (3) months, the Department will count the current federal minimum wage times the number of activity hours being claimed to determine child care benefits. (____)

302. ~~*CONVERTING*~~ EXCLUDED INCOME~~*—OR—EXPENSES—TO—A—MONTHLY AMOUNT*~~.
~~*If a full month's income is expected, but income is received more often than monthly, convert the income to a monthly amount. If a full month's expense is expected, but is billed more often than monthly, convert the expense to a monthly amount. Use the appropriate formula in Subsections 302.01 through 302.03 of these rules.*~~ The following sources of income are not counted as family income. ~~*(5-3-03)*~~(____)

01. ~~***Weekly Amount**. Multiply a weekly amount by four point three (4.3).*~~ **Earned Income of a Dependent Child**. Income earned by a dependent child under age eighteen (18) is not counted, unless the child is a parent who is seeking or receiving child care benefits. ~~*(5-3-03)*~~(____)

02. ~~***Bi-Weekly Amount**. Multiply a bi-weekly amount by two point fifteen (2.15).*~~ **Income Received for Person Not Residing With the Family**. Income received on behalf of a person who is not living in the home. ~~*(5-3-03)*~~(____)

03. ~~***Semi-Monthly Amount**. Multiply a semi-monthly amount by two (2).*~~ **Educational Funds**. All educational funds including grants, scholarships, an AmeriCorps Education Award, and federal and state work-study income. ~~*(5-3-03)*~~(____)

04. Assistance. Assistance to meet a specific need from other organizations and agencies. (____)

05. Lump Sum Income. Non-recurring or lump sum income is excluded as income if it is used to pay medical bills resulting from accident or injury, or used to pay funeral or burial costs. When lump sum income, minus exclusions, exceeds current income limits for a family of the same size, the family is not eligible to receive child care benefits. The period of ineligibility is computed by dividing the lump sum payment by the family's monthly income limit. In no case will the period of ineligibility exceed twelve (12) months. (____)

06. **Loans**. Loans with written, signed repayment agreements. ( )

07. **TAFI and AABD Benefits**. TAFI and AABD benefits. ( )

08. **Foster Care Payments**. Foster care payments. ( )

09. **AmeriCorps/VISTA Volunteers**. Living allowances, wages and stipends paid to AmeriCorps or VISTA volunteers under 42 U.C.S. 5044, P.L. 93-113, Title IV, Section 404(g) are excluded as income. ( )

10. **Income Tax Refunds and Earned Income Tax Credits**. Income tax refunds and earned income tax credits are excluded as income. ( )

11. **Travel Reimbursements**. Reimbursements from employers for work-related travel. ( )

12. **Tribal Income**. Income received from a tribe for any purpose other than direct wages. ( )

13. **Foster Parents' Income**. Income of licensed foster parents is excluded when determining eligibility for a foster child. Income is counted when determining eligibility for the foster parent's own child(ren). ( )

14. **Adoption Assistance**. Adoption assistance payments are excluded from income. ( )

15. **Child Support Payments**. Court-ordered child support payments made by the parent(s) who receive the child care benefits are deducted from income used to determine eligibility. Both the legal obligation to pay child support and the actual amount paid must be verified. ( )

~~***303. 304. (RESERVED).***~~

303. COMPUTING NON-FARMING SELF-EMPLOYMENT INCOME.
Compute non-farming self-employment income by adding projected monthly earnings to projected capital gains and subtracting the self-employment standard deduction. ( )

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 the using one (1) of the following: ( )

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. ( )

b. If no tax return is available, the self-employment income is averaged over the period of time the enterprise has been in operation, ( )

02. **Add Monthly Capital Gains Income**. 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. 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 303.01 of these rules to determine the gross monthly income. ( )

03. **Subtract Non-Farming Self-Employment Standard Deduction**. 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. ( )

304. **COMPUTING FARMING SELF-EMPLOYMENT INCOME.**
For farming self-employment, compute net income by subtracting allowable expenses from the gross income as follows in Subsections 304.01 through 304.04 of these rules. ( )

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: ( )

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. ( )

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, ( )

02. **Add Monthly Capital Gains Income**. 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. 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 304.01 of these rules to determine the gross monthly income. ( )

03. **Subtract Allowable Expenses**. Subtract any allowable expenses for farming self-employment, except those listed in Subsection 304.04 of these rules for expenses that are not allowed. This is the projected farming self-employment monthly income. ( )

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. ( )

a. Net losses from previous certification periods; ( )

b. Federal, State, and local income taxes; ( )

c. Money set aside for retirement; ( )

d. Work related personal expenses such as transportation to and from work; and ( )

e. Depreciation. ( )

~~***305. AMOUNT OF PAYMENT.***~~
~~*Child Care payments will be based on Subsections 305.01 through 305.04 of these rules. (5-3-03)*~~

~~***01. Payment Rate**. Payment will be based on the lower of the billed cost of child care, or the local market rate. (5-3-03)*~~

~~***a.** The local market rate will be set at the seventy-fifth percentile of the range of child care charges for that type of care. The rates will be established from a survey of providers of child care. (7-1-99)*~~

~~***b.** Each Region has a separate local market rate. Payment rates will be determined by the location of the child care facility. (7-1-99)*~~

~~***c.** If the child care facility is not in Idaho, the local market rate will be the rate where the family lives. (7-1-99)*~~

~~***d.** The rate survey will be conducted at least every two (2) years. (7-1-99)*~~

~~***02. Usual and Customary Rates**. Rates charged by the child care provider must not exceed usual and customary rates charged to all families. (7-1-99)*~~

~~***03. In-Home Care**. Parents are responsible to pay persons providing care in the child's home the minimum wage, as required by the Fair Labor Standards Act (29 U.S.C. 206a) and other applicable state and federal requirements. Department payments must not exceed the lower of the hourly Federal minimum wage or actual cost of care. Care provided in the home of the child will be paid only when three (3) or more children are eligible and receiving payments. Fewer than three (3) children will receive payment for in-home care only when one (1) of the following special circumstances is met: (5-3-03)*~~

~~***a.** Parents' or caretakers' activity occurs during times when out-of-home care is not available. (5-3-03)*~~

~~***b.** The family lives in an area where out-of-home care is not available. (5-3-03)*~~

~~***c.** A child has a verified illness or disability which would place the child or other children in an out-of-home facility at risk. (7-1-99)*~~

~~***04. Payments**. Payments will be issued directly to eligible providers. A warrant may be issued to a parent only when the parent provides proof the provider was paid in full, and no longer provides child care for the family. (5-3-03)*~~

~~***306. (RESERVED).***~~

307. SLIDING FEE SCHEDULES.
Eligible families, except TAFI families participating in non-employment TAFI activities, must pay part of their child care costs. *(7-1-99)*

***01. Poverty Rates**. Poverty rates will be the established rates published annually in the Federal Register. The monthly rate will be calculated by dividing the yearly rate by twelve (12).* *(7-1-99)*

***02. Calculating Family Payment**. Families must pay the provider for child care services. Family income for the month of the child care will determine the family share of child care costs. The payment made by the Department will be the allowable local market rate, less the amount calculated using the sliding fee schedule listed in Table 307.03.* *(3-16-04)*

***03. Maximum Income And Sliding Fee Schedules**:*

FAMILY CO-PAYMENT REQUIREMENTS - ICCP SLIDING FEE SCHEDULE									
FAMILY SIZE	2	3	4	5	6	7	8	9	10
MONTHLY INCOME	PERCENTAGE OF CHILD CARE COST FAMILY MUST PAY								
$0 - $499	7%	7%	7%	7%	7%	7%	7%	7%	7%
$500 - $599	11%	7%	7%	7%	7%	7%	7%	7%	7%
$600 - $699	11%	11%	7%	7%	7%	7%	7%	7%	7%
$700 - $799	11%	11%	11%	7%	7%	7%	7%	7%	7%
$800 - $899	21%	11%	11%	11%	7%	7%	7%	7%	7%
$900 - $999	21%	11%	11%	11%	11%	7%	7%	7%	7%
$1,000 - $1,099	21%	11%	11%	11%	11%	7%	7%	7%	7%
$1,100 - $1,199	36%	21%	11%	11%	11%	11%	7%	7%	7%
$1,200 - $1,299	36%	21%	11%	11%	11%	11%	11%	7%	7%
$1,300 - $1,356	66%	21%	21%	11%	11%	11%	11%	7%	7%
$1,357 - $1,399	100%	21%	21%	11%	11%	11%	11%	7%	7%
$1,400 - $1,499	100%	36%	21%	11%	11%	11%	11%	11%	7%
$1,500 - $1,599	100%	36%	21%	21%	11%	11%	11%	11%	11%
$1,600 - $1,699	100%	66%	36%	21%	11%	11%	11%	11%	11%
$1,700 - $1,706	100%	66%	36%	21%	21%	11%	11%	11%	11%
$1,707 - $1,799	100%	100%	36%	21%	21%	11%	11%	11%	11%
$1,800 - $1,899	100%	100%	36%	21%	21%	11%	11%	11%	11%
$1,900 - $1,999	100%	100%	36%	36%	21%	11%	11%	11%	11%
$2,000 - $2,056	100%	100%	66%	36%	21%	21%	11%	11%	11%
$2,057 - $2,099	100%	100%	100%	36%	21%	21%	11%	11%	11%

~~FAMILY CO-PAYMENT REQUIREMENTS - ICCP SLIDING FEE SCHEDULE~~									
~~FAMILY SIZE~~	~~2~~	~~3~~	~~4~~	~~5~~	~~6~~	~~7~~	~~8~~	~~9~~	~~10~~
~~MONTHLY INCOME~~	~~PERCENTAGE OF CHILD CARE COST FAMILY MUST PAY~~								
~~$2,100 - $2,199~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~21%~~	~~21%~~	~~11%~~	~~11%~~	~~11%~~
~~$2,200 - $2,299~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~21%~~	~~21%~~	~~21%~~	~~11%~~	~~11%~~
~~$2,300 - $2,399~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~	~~21%~~	~~21%~~	~~11%~~	~~11%~~
~~$2,400 - $2,406~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~	~~21%~~	~~21%~~	~~21%~~	~~11%~~
~~$2,407 - $2,499~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~21%~~	~~21%~~	~~21%~~	~~11%~~
~~$2,500 - $2,599~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~21%~~	~~21%~~	~~21%~~	~~11%~~
~~$2,600 - $2,699~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~	~~21%~~	~~21%~~	~~21%~~
~~$2,700 - $2,756~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~	~~21%~~	~~21%~~	~~21%~~
~~$2,757 - $2,799~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~21%~~	~~21%~~	~~21%~~
~~$2,800 - $2,899~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~21%~~	~~21%~~	~~21%~~
~~$2,900 - $2,999~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~36%~~	~~21%~~	~~21%~~
~~$3,000 - $3,099~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~	~~21%~~	~~21%~~
~~$3,100 - $3,106~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~	~~21%~~	~~21%~~
~~$3,107 - $3,199~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~21%~~	~~21%~~
~~$3,200 - $3,299~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~36%~~	~~21%~~
~~$3,300 - $3,399~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~	~~21%~~
~~$3,400 - $3,456~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~	~~21%~~
~~$3,457 - $3,499~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~21%~~
~~$3,500 - $3,599~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~36%~~
~~$3,600 - $3,699~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~	~~36%~~
~~$3,700 - $3,799~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~
~~$3,800 - $3,806~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~	~~36%~~
~~$3,807 - $3,899~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~
~~$3,900 - $3,999~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~36%~~
~~$4,000 - $4,099~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~
~~$4,100 - $4,156~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~66%~~
~~$4,157 - $4,299~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~	~~100%~~

~~FAMILY CO-PAYMENT REQUIREMENTS - ICCP SLIDING FEE SCHEDULE~~									
~~FAMILY SIZE~~	~~2~~	~~3~~	~~4~~	~~5~~	~~6~~	~~7~~	~~8~~	~~9~~	~~10~~
~~MONTHLY INCOME~~	~~PERCENTAGE OF CHILD CARE COST FAMILY MUST PAY~~								
~~* Maximum income for ICCP benefits:~~ ~~$1,356 for household of 2~~ ~~$1,706 for household of 3~~ ~~$2,056 for household of 4~~ ~~$2,406 for household of 5~~ ~~$2,756 for household of 6~~ ~~$3,106 for household of 7~~ ~~$3,456 for household of 8~~ ~~$3,806 for household of 9~~ ~~$4,156 for household of 10~~									

~~*Maximum Income (or Eligibility for Payment) Based on 150% of Poverty (1998 Poverty Tables).~~ ~~(3-16-04)~~

~~**308. ACTION ON CHANGES.**~~
~~Action on reported changes must be taken as listed in Subsections 308.01 through 308.03 of these rules.~~ ~~(5-3-03)~~

~~**01. Change in Income or Hours of Activity**. If a change in income or hours of qualified activity is reported, and results in a decrease in the subsidy amount, the change becomes effective the month following the month the change is reported.~~ ~~(5-3-03)~~

~~**02. Change in Income or Hours of Activity and Billed Amount**. If changes in the income or hours of qualified activity, and the billed amount of child care, are reported and result in a decrease in the subsidy amount, the change can be made effective in the current month.~~ ~~(5-3-03)~~

~~**03. Changes Resulting in an Increase**. Changes resulting in an increase in the subsidy amount must be acted on for the current month.~~ ~~(5-3-03)~~

~~**309. REDETERMINATION.**~~
~~Eligibility must be redetermined in all cases as listed in Subsections 309.01 through 309.03 of these rules.~~ ~~(5-3-03)~~

~~**01. Work Search**. Eligibility for individuals participating in work search must be redetermined every thirty (30) days.~~ ~~(5-3-03)~~

~~**02. Preventive Services**. Eligibility for cases where child care is needed for preventive services must be redetermined every three (3) months.~~ ~~(5-3-03)~~

~~**03. All Other Cases**. Eligibility for all other cases must be redetermined at least every six (6) months.~~ ~~(5-3-03)~~

~~310. COMPLAINT PROCEDURE.~~
~~The Department shall maintain a record of substantiated parental complaints. Information regarding substantiated parental complaints shall be made available to the public on request, in accordance with the Idaho Public Records Act. (7-1-99)~~

~~311. (RESERVED).~~

~~312. OVERPAYMENTS AND RECOVERY.~~
~~Overpayments may occur for child care services as the result of agency error, family or provider error, Intentional Program Violations (IPV), or fraud as established by a judicial or administrative determination as described in Section 56-227, Idaho Code. Recovery of overpayments based on agency error may be pursued from parents or providers where the overpayment is one hundred dollars ($100), or more. Overpayments due to IPV or fraud must be recovered in full. The Department will determine overpayments. (5-3-03)~~

~~01. Providers Must Repay~~. *~~Providers must repay overpayments resulting from their failure to report changes within time limits. Repayment schedules will be negotiated with the Department. Failure to comply with the negotiated repayment agreement will result in disqualification of the provider. Disqualification will continue until repayment is made or a new repayment agreement is negotiated. (5-3-03)~~*

~~02. Parents Must Repay~~. *~~Parents must repay overpayments resulting from their failure to report changes within time limits. Repayment schedules will be negotiated with the Department. Failure to comply with the negotiated repayment agreement will result in disqualification of the family. Disqualification will continue until repayment is made or a new repayment agreement is negotiated. (5-3-03)~~*

~~313. INTENTIONAL PROGRAM VIOLATIONS (IPV).~~
~~An IPV is an intentionally false or misleading action or statement as defined in Subsections 313.01 through 313.03 of these rules. An IPV will be established when a family member or the child care provider admits the IPV in writing and waives the right to an administrative hearing, or when determined by an administrative hearing, a court decision, or through deferred adjudication. Deferred adjudication exists when the court defers a determination of guilt because the accused family member or child care provider meets the terms of a court order or an agreement with the prosecutor. (5-3-03)~~

~~01. False Statement~~. *~~An individual makes a false statement to the Department, either orally or in writing, to participate in the Idaho Child Care Program. (5-3-03)~~*

~~02. Misleading Statement~~. *~~An individual makes a misleading statement to the Department, either orally or in writing, to participate in the Idaho Child Care Program. (5-3-03)~~*

~~03. Misrepresentation of Facts~~. *~~An individual misrepresents facts to the Department, either orally or in writing, to participate in the Idaho Child Care Program. (5-3-03)~~*

~~04. Concealing Facts~~. *~~An individual conceals or withholds facts to participate in the Idaho Child Care Program. (5-3-03)~~*

~~***314. PENALTIES FOR AN IPV.***~~
~~*When the Department makes an IPV determination, the entire family, or the child care provider, is ineligible for the period of time listed in Subsections 314.01 through 314.03 of these rules.* *(5-3-03)*~~

~~***01. First Offense**. Twelve (12) months for the first IPV or fraud offense, or the length of time specified by the court.* *(5-3-03)*~~

~~***02. Second Offense**. Twenty-four (24) months for the second IPV or fraud offense, or the length of time specified by the court.* *(5-3-03)*~~

~~***03. Third Offense**. Permanent disqualification for the third or subsequent IPV or fraud offense, or the length of time specified by the court.* *(5-3-03*~~

~~***315. UNDERPAYMENT.***~~
~~*Supplemental payment shall be made to a family entitled to an additional payment.* *(5-3-03)*~~

~~***316. FUNDING RESTRICTIONS.***~~
~~*If a funding shortfall is projected, the Department shall take action to ensure the program operates within financial resources.* *(5-3-03)*~~

~~***317. CONFIDENTIALITY.***~~
~~*Information received by ICCP from families is subject to the provisions of Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records."* *(7-1-99)*~~

305. -- 399. (RESERVED).

IN-HOME CARE REQUIREMENTS

(Sections 400 through 499)

400. REQUIREMENTS FOR IN-HOME CARE UNDER ICCP.
Parents must contact the Department to request approval of in-home child care. Only parents who have qualified activities outside their home will be considered for in-home care approval. The Department limits the approval of all in-home child care under ICCP to the following circumstances: ( )

01. Three or More Children in the Home. There are three (3) or more children in the home who are eligible for ICCP and require child care. ( )

02. Fewer Than Three Children in the Home. If there are fewer than three (3) children in the home who are eligible for ICCP and require child care, in-home care will be approved by the Department only when one (1) of the following special circumstances are met:

( )

a. Parents' qualifying activity occurs during times when out-of-home care is not available. If child care is needed during any period when out-of home care is not available, in-home care will be approved for the entire time care is needed. A family is not expected to change between out-of-home and in-home care. ( )

b. The family lives in an area where out-of-home care is not available. ( )

c. A child has a verified illness or disability that would place the child or other children in an out-of-home facility at risk. ( )

401. -- 499. (RESERVED).

PAYMENT INFORMATION

(Sections 500 through 599)

500. ALLOWABLE CHILD CARE COSTS.
Care provided to an eligible child by an eligible child care provider is payable subject to the following conditions: ( )

01. Payment for Employment, Training, Education, or Preventive Service Hours. Child care must be reasonably related to the hours of the parent's qualifying activities. Travel time is included in determining qualifying activities. ( )

02. Family Member or Guardian Not Payable. A parent, step-parent, or unmarried parent will not be paid for providing child care to his child. A guardian will not be paid for providing child care to his ward. Absent parents, or anyone living in the absent parent's home are not eligible to receive ICCP payment.. ( )

03. One-Time Registration Fees. One-time fees for registering a child in a child care facility are payable above the local market rate, if the fee is charged to all who enroll in the facility. Fees may not exceed usual and customary rates charged to all families. Registration fees are separate from local market rates. ( )

04. Local Market Rates (LMR) for Child Care. The local market rates are the maximum monthly amounts that ICCP will pay for any given category of child care in a geographic area designated by the Department. The local market rates for child care are established based on a comprehensive survey of child care providers. Using information gathered in the survey, including the age of child, the type of child care, and the designated area where the provider does business, a local market rate is specified for each category of child care. The rate survey is conducted biannually. However, due to budgetary considerations, the Department may opt not to update the rate structure following a survey. ( )

501. AMOUNT OF PAYMENT.
Child Care payments will be based on Subsections 501.01 through 501.04 of these rules. ( )

01. Payment Rate. Payment will be based on the lower of the billed cost of child care, or the local market rate. ( )

a. The local market rate is determined from a survey of providers' child care charges which is conducted every two years. The local market rate is set at the seventy-fifth percentile and updated as the budget allows. ( )

b. Each Region has a separate local market rate. Payment rates will be determined by the location of the child care facility. ( )

c. If the child care facility is not in Idaho, the local market rate will be the rate where the family lives. ( )

d. The rate survey will be conducted at least every two (2) years. ( )

02. Usual and Customary Rates. Rates charged by the child care provider must not exceed the usual and customary rates charged to all families. ( )

03. In-Home Care. Parents are responsible to pay persons providing care in the child's home the minimum wage, as required by the Fair Labor Standards Act (29 U.S.C. 206a) and other applicable state and federal requirements. Department payments must not exceed the lower of the hourly federal minimum wage or actual cost of care. ( )

04. Payments. Payments will be issued directly to eligible providers. A warrant may be issued to a parent only when the parent provides proof the provider was paid in full, and no longer provides child care for the family. ( )

502. SLIDING FEE SCHEDULES.
Eligible families, except TAFI families participating in non-employment TAFI activities, must pay part of their child care costs. ( )

01. Poverty Rates. Poverty rates will be one hundred thirty-five percent (135%) of the 2007 federal poverty guidelines published in the Federal Register. The monthly rate will be calculated by dividing the yearly rate by twelve (12). ( )

02. Calculating Family Payment. Families must pay the provider their share of costs for child care services which include the families' co-payments and any charges not paid by the Department. Family income and activity for the month of the child care will determine the family share of child care costs. The payment made by the Department will be the allowable local market rate or billed costs, whichever is lower, less the co-payment listed in the following table: ( )

03. ICCP Sliding Fee Schedule.

ICCP SLIDING FEE SCHEDULE									
Family Size	2	3	4	5	6	7	8	9	10
Percent Co-pay	MONTHLY INCOME LIMITS								
7%	$499	$599	$699	$799	$899	$1,099	$1,199	$1,399	$1,499
11%	$799	$1,099	$1,299	$1,499	$1,699	$1,999	$2,199	$2,399	$2,599
16%	$949	$1,249	$1,449	$1,699	$1,999	$2,299	$2,549	$2,799	$3,049
21%	$1,099	$1,399	$1,599	$1,899	$2,299	$2,599	$2,899	$3,199	$3,499
26%	$1,165	$1,465	$1,731	$2,031	$2,399	$2,731	$3,031	$3,365	$3,665
31%	$1,231	$1,531	$1,863	$2,163	$2,499	$2,863	$3,163	$3,531	$3,831
36%	$1,299	$1,599	$1,999	$2,299	$2,599	$2,999	$3,299	$3,699	$3,999
41%	$1,308	$1,616	$2,008	$2,316	$2,625	$3,016	$3,325	$3,716	$4,025
46%	$1,317	$1,633	$2,017	$2,333	$2,651	$3,033	$3,351	$3,733	$4,051
51%	$1,326	$1,650	$2,026	$2,350	$2,677	$3,050	$3,377	$3,750	$4,077
56%	$1,335	$1,667	$2,035	$2,367	$2,703	$3,067	$3,403	$3,767	$4,103
61%	$1,344	$1,684	$2,044	$2,384	$2,729	$3,084	$3,429	$3,784	$4,129
66%	$1,356	$1,706	$2,056	$2,406	$2,756	$3,106	$3,456	$3,806	$4,156
71%	$1,386	$1,743	$2,100	$2,457	$2,814	$3,171	$3,528	$3,885	$4,242
76%	$1,416	$1,780	$2,144	$2,508	$2,872	$3,236	$3,600	$3,964	$4,328
81%	$1,446	$1,817	$2,188	$2,559	$2,930	$3,301	$3,672	$4,043	$4,414
86%	$1,476	$1,854	$2,232	$2,610	$2,988	$3,366	$3,744	$4,122	$4,500
91%	$1,506	$1,891	$2,276	$2,661	$3,046	$3,431	$3,816	$4,201	$4,586
96%	$1,540	$1,932	$2,323	$2,715	$3,106	$3,498	$3,889	$4,281	$4,672

(____)

503. (RESERVED).

504. INTERIM CHILD CARE PAYMENT.
A family that uses a relative provider is not eligible for interim child care payments. If child care arrangements would otherwise be lost, child care may be paid under the following conditions: (____)

01. Break in Employment or Education. During a break in employment or education of one (1) month or less. (____)

02. Children Temporarily Out of the Home. While children are temporarily away from the home for a period of one (1) month or less. (____)

505. -- 599. (RESERVED).

CHANGE REPORTING REQUIREMENTS FOR THOSE RECEIVING CHILD CARE BENEFITS

(Sections 600 through 699)

600. DEPARTMENT ACTION ON CHANGES.
The Department must take action on the following reported changes: ( )

01. Change in Income or Hours of Activity. If a change in income or hours of qualifying activity results in a decrease in the amount of the child care benefit, the Department will make the change effective the month following the month the change is reported. ( )

02. Change in Billed Amount. If the billed amount of child care results in a decrease in the amount of the child care benefit, the Department will make the changes effective in the month the changes were reported. ( )

03. Change Resulting in an Increase. If a change results in an increase in the amount of the child care benefit, the Department will make the change effective in the month the changes were reported. ( )

601. REDETERMINATION OF ELIGIBILITY FOR CHILD CARE BENEFITS.
The Department must redetermine eligibility for child care benefits at least every six (6) months. Eligibility must be redetermined more often than every six (6) months for the following qualifying activities: ( )

01. Preventive Services. The Department must redetermine eligibility every three (3) months for each family in which child care is needed for preventive services. ( )

02. Education Activities. The Department must redetermine eligibility at the end of each semester or term for parents engaged in educational activities. ( )

602. -- 699. (RESERVED).

PAYMENT ADJUSTMENTS AND PENALTIES

(Sections 700 through 704)

700. UNDERPAYMENT OF CHILD CARE BENEFITS.
When the Department has underpaid a family's child care benefits, a supplemental payment will

be made. ( )

701. OVERPAYMENTS AND RECOVERY.
An overpayment for child care services may occur as the result of Department, family or provider error, intentional program violations (IPV), or fraud, as established by a judicial or administrative determination as described in Section 56-227, Idaho Code. Recovery of an overpayment based on Department error may be collected from parents or providers when the overpayment is one hundred dollars ($100), or more. An overpayment due to family or provider error, IPV or fraud must be recovered in full. ( )

01. Provider Repayment Requirement. A provider must repay any overpayment resulting from the provider's failure to report changes within ten (10) days as required under Section 808 of these rules. A provider may negotiate a repayment schedule with the Department. Failure to comply with the negotiated repayment agreement will result in loss of eligibility to receive ICCP payments. Ineligibility will continue until the provider repays the overpayment or a new repayment agreement is negotiated with the Department. ( )

02. Parental Repayment Requirement. A parent must repay any overpayment resulting from the parent's failure to report changes within ten (10) days as required in Section 201 of these rules. The parent may negotiate a repayment schedule with the Department. Failure to comply with the negotiated repayment agreement will result in loss of the family's eligibility to receive child care benefits. Ineligibility will continue until the parent repays the overpayment or a new repayment agreement is negotiated with the Department. ( )

702. INTENTIONAL PROGRAM VIOLATIONS (IPV).
An IPV is an intentionally false or misleading action or statement as identified below in Subsections 702.01 through 702.08 of this rule. An IPV is established when a family member or the child care provider admits the IPV in writing and waives the right to an administrative hearing, or when determined by an administrative hearing, a court decision, or through deferred adjudication. Deferred adjudication exists when the court defers a determination of guilt because the accused family member or child care provider meets the terms of a court order or an agreement with the prosecutor. ( )

01. False Statement. An individual makes a false statement to the Department, either orally or in writing, in order to participate in the Idaho Child Care Program. ( )

02. Misleading Statement. An individual makes a misleading statement to the Department, either orally or in writing, to participate in the Idaho Child Care Program. ( )

03. Misrepresentation of Fact. An individual misrepresents one (1) or more facts to the Department, either orally or in writing, to participate in the Idaho Child Care Program. ( )

04. Concealing Fact. An individual conceals or withholds one (1) or more facts to participate in the Idaho Child Care Program. ( )

05. Non-Compliance With Rules and Regulations. An individual fails repeatedly or substantially to comply with this chapter of rules. ( )

06. Violation of Provider Agreement. An individual knowingly violates any term of his provider agreement. ( )

07. Failure to Repay. An individual has failed to repay, or was a managing employee or had an ownership or control interest in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation, or provider agreement. ( )

08. Failure to Meet Qualifications. A provider fails to meet the qualifications specifically required by this chapter of rules or by any applicable licensing board. ( )

703. PENALTIES FOR AN IPV.
When the Department determines an IPV was committed, the party who committed the IPV loses eligibility for ICCP. If an individual has committed an IPV, the entire family is ineligible for child care benefits. If a child care provider has committed an IPV, the provider is ineligible to receive payments. The period of ineligibility for each offense, for both participants and providers, is as follows: ( )

01. First Offense. Twelve (12) months, for the first IPV or fraud offense, or the length of time specified by the court. ( )

02. Second Offense. Twenty-four (24) months for the second IPV or fraud offense, or the length of time specified by the court. ( )

03. Third Offense. Permanent ineligibility for the third or subsequent IPV or fraud offense, or the length of time specified by the court. ( )

704. FUNDING RESTRICTIONS.
If a funding shortfall is projected, the Department may reduce child care benefits to ensure that ICCP operates within its financial resources. ( )

705. -- 799. (RESERVED).

PROVIDER ELIGIBILITY

(Sections 800 through 808)

800. CHILD CARE PROVIDER LICENSING.
All providers of child care who receive a Department subsidy must be licensed or must comply with: applicable State Day Care licensing requirements in Title 39, Chapter 11, Idaho Code; these rules; local licensing ordinances; or tribal ordinances. If both state requirements and ordinances apply to a provider, the provider must comply with the stricter requirement. A provider operating outside Idaho must comply with the licensing laws of his state or locality. ( )

801. LIMIT ON PROVIDER PAYMENT.

ICCP will not pay for in-home child care if the provider lives at the same address as the child, unless the child care provider is a relative who is not acting "in loco parentis." A roommate, significant other, cousin, or any other individual that lives in the same home as the child will not be paid for providing child care. ( )

802. HEALTH AND SAFETY REQUIREMENTS.
All providers must submit a written statement that they comply with the health and safety requirements listed in Subsections 802.01 through 802.10 of these rules. The provider must agree to a health and safety inspection. Compliance with these standards does not exempt a provider from complying with stricter health and safety standards under state law, tribal law, local ordinance, or other applicable law. ( )

01. Age of Provider. All child care providers providing services must be eighteen (18) years old or older. Persons sixteen (16) or seventeen (17) years old may provide child care if they have direct, on-site supervision from a licensed child care provider who is at least eighteen (18) years old. ( )

02. Sanitary Food Preparation. Food for use in child care facilities must be prepared and served in a sanitary manner. Utensils and food preparation surfaces must be cleaned and sanitized before using to prevent contamination. ( )

03. Food Storage. All food served in child care facilities must be stored to protect it from potential contamination. ( )

04. Hazardous Substances. Medicines, cleaning supplies, and other hazardous substances must be stored out of the reach of children. ( )

05. Emergency Communication. A telephone or some type of emergency communication system is required. ( )

06. Smoke Detectors, Fire Extinguishers, and Exits. A properly installed and operational smoke detector must be on the premises where child care occurs. Adequate fire extinguishers and fire exits must be available on the premises. ( )

07. Hand Washing. Each provider must wash his hands with soap and water at regular intervals, including before feeding, after diapering or assisting children with toileting, after nose wiping, and after administering first aid. ( )

08. CPR/First Aid. Providers must insure that at all times children are present at least one (1) adult on the premises has current certification in pediatric rescue breathing and first aid treatment from a certified instructor. ( )

09. Health of Provider. Each provider must certify that he does not have a communicable disease or any physical or psychological condition that might pose a threat to the safety of a child in his care. ( )

10. Child Abuse. Providers must report suspected child abuse to the appropriate authority. ( )

803. TEMPORARY REGISTRATION OF AN ICCP PENDING COMPLETION OF THE HEALTH DISTRICT INSPECTION.
The Department may issue a temporary registration to an ICCP provider applicant pending completion of the necessary Health District inspection and CPR/First Aid Certification. All temporary ICCP registration will be issued under the following conditions: ( )

01. Length of Temporary Registration. A temporary registration will be issued for a period of time not to exceed ninety (90) days, unless otherwise extended by the Department. ( )

02. Applicants Must Sign a Provider Agreement. All ICCP provider applicants must sign the ICCP provider agreement prior to issuance of a temporary registration. ( )

804. CHILD CARE PROVIDER AGREEMENT.
All providers must sign and comply with a provider agreement. ( )

805. CONVICTION OR WITHHELD JUDGMENT.
A child care provider must sign a self-declaration attesting he has not been convicted or received a withheld judgement for any of the following crimes: homicide; kidnaping; arson; assault and battery; sexual abuse of a child; a sex crime as defined in Chapter 66, Title 18, Idaho Code; rape as defined in Chapter 61, Title 18, Idaho Code; injuring a child as defined in Section 18-1501, Idaho Code: selling or bartering a child as defined in Section 18-1511, Idaho Code; sexually abusing a child as defined in Section 18-1506, Idaho Code; sexually exploiting a child as defined in Section 18-1507, Idaho Code; or any similar provision in another jurisdiction. ( )

806. PURVIEW OF CHILD PROTECTIVE ACT OR JUVENILE JUSTICE REFORM ACT.
Providers must certify that they are not, through stipulation or adjudication, under the purview of the Child Protective Act, Section 16-1600, Idaho Code, or the Juvenile Corrections Act, Section 20-501 through 20-547, Idaho Code. Any person who has a substantiated child protection complaint cannot be a provider. ( )

807. PARENT OR CARETAKER ACCESS TO CHILD CARE PREMISES.
Providers serving families who receive a child care subsidy shall allow parents or caretakers unlimited access to their children and to persons giving care, except that access to children will not be required if prohibited by court order. ( )

808. REPORTING REQUIREMENTS FOR PROVIDERS.
A child care provider must report any of the following changes within ten (10) days: ( )

01. Change in Provider Charges. The provider changes any rate for child care services. ( )

02. Child Stops Attending Care. A child covered under ICCP stops attending child care, or is taken to another child care provider. ( )

03. Change of Provider Address. The provider changes the location where child care

is provided. ( )

04. **Change in Who Lives in Home**. An individual who provides child care in his home must report when any other person moves into the home. ( )

05. **Intent Not to Renew License**. The provider intends not to renew his license, or other required certifications. ( )

~~31~~809. -- 999. (RESERVED).

IDAPA 22 - IDAHO BOARD OF MEDICINE

22.01.05 - RULES GOVERNING THE LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPY ASSISTANTS

DOCKET NO. 22-0105-0601 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2008 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 54-1806(2), Idaho Code.

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

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the Idaho Administrative Bulletin, Volume 06-12, December 6, 2006, page 90.

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 rule, contact Nancy M. Kerr, Idaho State Board of Medicine, (208)-327-7000.

DATED this 21st day of May, 2007.

Nancy M. Kerr
Executive Director
Idaho State Board of Medicine
1755 Westgate Drive
PO Box 83720
Boise, Idaho 83720-0058
(208) 327-7000
Fax (208) 327-7005)

IDAHO BOARD OF MEDICINE ***Docket No. 22-0105-0601***
Licensure of Physical Therapists & Assistants ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 13, 2006.

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has adopted temporary and proposed rulemaking procedures. The action is authorized pursuant to Title 54, Chapter 18, Idaho Code.

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

Pursuant to Section 67-5226(1)(b), Idaho Code, the rule is repealed to comply with 2006 amendments to Title 54, Chapter 22, Idaho Code. House Bill 619 transfers rulemaking authority for Physical Therapists and Physical Therapy Assistants to the Department of Self Regulating Agencies, Bureau of Occupational Licenses, Board of Physical Therapy.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1) (b) Idaho Code, to comply with amendments to governing law the rule is repealed. House Bill 619 transfers rulemaking authority for Physical Therapists and Physical Therapy Assistants to the Department of Self-Regulating Agencies, Bureau of Occupational Licenses, Board of Physical Therapy.

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 repeal was required due to a change in statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

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 December 27, 2006.

DATED this 13th day of October, 2006.

IDAPA 22.10.05 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 22 - IDAHO BOARD OF MEDICINE

22.01.06 - RULES FOR EMS PERSONNEL

DOCKET NO. 22-0106-0601 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2008 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 54-1806(2) Idaho Code.

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

The pending rules are being adopted as proposed. The original text of the proposed rules was published in the Idaho Administrative Bulletin, Volume 06-12, December 6, 2006, page 91.

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 rule, contact Nancy M. Kerr, Idaho State Board of Medicine, (208)-327-7000.

DATED this 21st day of May, 2007.

Nancy M. Kerr
Executive Director
Idaho State Board of Medicine
1755 Westgate Drive
PO Box 83720
Boise, Idaho 83720-0058
(208) 327-7000
Fax (208) 327-7005

IDAHO BOARD OF MEDICINE ***Docket No. 22-0106-0601***
Rules for EMS Personnel ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 13, 2006.

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has adopted temporary and proposed rulemaking procedures. The action is authorized pursuant to Title 54, Chapter 18, Idaho Code, and amended Section(s) 56-1017, Idaho Code.

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

Pursuant to Section 67-5226(1)(b), Idaho Code, the rule is repealed to comply with amendments to governing law. Senate Bill 1342 transfers rulemaking authority for EMS personnel to the Department of Health and Welfare, Emergency Services Physician Commission.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(b) Idaho Code, to comply with amendments to governing law the rule is repealed. Senate Bill 1342 transferred rule making authority for EMS personnel to the Department of Health and Welfare, Emergency Medical Services Physician Commission.

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 repeal was required due to a change in statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Nancy M. Kerr, Executive Director, Idaho State Board of Medicine, (208) 327-7000.

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 December 27, 2006.

DATED this 13th day of October, 2006.

IDAPA 22.01.06 IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 23 - IDAHO BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-0702

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-1404 and 54-1406A, 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 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 101 through 104.

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 Sandra Evans, MAEd., R.N., Executive Director, (208) 334-3110 x26.

DATED this 29th day of October, 2007.

Sandra Evans, MAEd., R.N.
Executive Director
Idaho Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
P. O. Box 83720, Boise, ID 83720-0061
Phone: (208) 334-3110 x26 / Facsimile: (208) 334-3262

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

IDAHO BOARD OF NURSING ***Docket No. 23-0101-0702***
Rules of the Idaho Board of Nursing ***PENDING RULE***

EFFECTIVE DATE: The effective date of the temporary rule is July 23, 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 rulemaking procedures have been initiated. The action is authorized pursuant to Sections 54-1404 and 54-1406A, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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 proposed changes are needed to confer a benefit to licensed nurses as an alternative to disciplinary proceedings. The proposed rules will clarify that nurses who have violated the terms of the program for recovering nurses will have their limited licenses summarily suspended, but in appropriate cases a nurse can remain in the program without being referred to the Board of Nursing for disciplinary proceedings.

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

The proposed changes are needed to confer a benefit to licensed nurses participating in the program for recovering nurses as an alternative to disciplinary proceedings.

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

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

NEGOTIATED RULEMAKING: Negotiated rulemaking was not utilized in view of the need for a temporary rule. This temporary rule is necessary in order to convey a benefit. The benefit is the creation of additional options within the program for recovering nurses and it is necessary to provide these alternatives to nurses who are current participants in the program.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Sandra Evans, MAEd., R.N., Executive Director, (208) 334-3110 x26.

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 24, 2007.

DATED this 14th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

132. LIMITED LICENSES.
Limited licenses may be issued to qualified individuals in four (4) categories: post-discipline, non-practicing status, restricted status, and impairment-related disability. Failure to comply with the terms and conditions of a limited license will be cause for summary suspension. (3-30-07)

01. Following Disciplinary Action. (3-30-07)

a. After evaluation of an application for licensure reinstatement, the Board may issue a limited license to a nurse whose license has been revoked. (3-15-02)

b. The Board shall specify the conditions of issuance of the limited license in writing. The conditions may be stated on the license. (3-15-02)

02. Non-Practicing Status. (3-15-02)

a. Individuals who are prevented from engaging in the active practice of nursing may be issued a limited license. (3-15-02)

b. The Board shall specify that the license being issued does not entitle the licensee to engage in the active practice of nursing. The non-practicing status shall be noted on the license. (3-15-02)

c. The non-practicing limitation may be removed by the Board following receipt and evaluation of evidence satisfactory to the Board confirming that the licensee's physical or mental health status no longer prevents the individual from engaging in the active practice of nursing. (3-15-02)

03. Restricted Status. (3-15-02)

a. Individuals whose disabilities restrict or inhibit their ability to provide a full range of nursing services may be issued a limited license. (3-15-02)

b. In order to determine the appropriate limitations, the Board may evaluate statements from qualified professional persons who have personal knowledge of the applicant or licensee. The Board may also evaluate job descriptions and statements from potential employers

and consider input from the applicant for the limited license. (3-15-02)

c. The Board shall specify the conditions of issuance of the limited license in writing. The conditions may be stated on the license. The conditions may include, but are not limited to: (3-15-02)

i. Notifying the Board of changes in employment status. (3-15-02)

ii. Submission of regular reports by the employer or by such other entities or individuals as the Board may desire. (3-15-02)

iii. Meeting with Board representatives. (3-15-02)

iv. Specific parameters of practice, excluding the performance of specific nursing functions. (3-15-02)

d. The conditions of limited practice may be removed by the Board following receipt and evaluation of satisfactory evidence confirming that the health status of the licensee no longer restricts or inhibits the person's ability to provide a full range of nursing services. (3-15-02)

04. Disability Due to Alcohol or Drug Use or Emotional or Mental Impairment. (3-15-02)

a. Individuals disabled due to alcohol or drug use or to emotional or mental impairment may qualify for issuance of a limited license as an alternative to discipline. (3-15-02)

b. The executive director may issue a limited license for a period not to exceed five (5) years to an individual who voluntarily surrenders his license by reason of a disability relating to alcohol or drug use or relating to emotional or mental impairment and who: (3-15-02)

i. Holds a current license to practice in Idaho as a professional or practical nurse or is otherwise eligible and is in the process of applying for licensure; and (3-30-07)

ii. Abused drugs and/or alcohol or demonstrated mental disability such that ability to safely practice is/may be impaired; and (3-15-02)

iii. Sign a written statement admitting to all facts which may constitute grounds for disciplinary action or demonstrate impairment of the safe practice of nursing, and waiving the right to a hearing and all other rights to due process in a contested case under the Idaho Administrative Procedures Act and the Nursing Practice Act; and (3-15-02)

iv. Submit reliable evidence, satisfactory to the executive director, that he is competent to safely practice nursing. (3-15-02)

c. If required, the applicant shall satisfactorily complete a treatment program accepted by the Board. (3-30-07)

d. The applicant must agree to participation in the Board's monitoring program to

include: (3-15-02)

i. Evaluation of disability; (5-21-89)

ii. Approval of treatment program regimen; (5-21-89)

iii. Monitoring of progress; (5-21-89)

iv. Determination of when return to the workplace will be allowed. (7-1-96)

e. Admission to the Program for Recovering Nurses and/or issuance of a limited license may be denied for any reason including, but not limited to the following: (3-15-02)

i. The applicant diverted controlled substances for other than self administration; or (3-15-02)

ii. The applicant creates too great a safety risk; or (3-15-02)

iii. The applicant has been terminated from this, or any other, alternative program for non-compliance. (3-15-02)

f. Upon satisfactory compliance with all of the terms of the limited license, and provided that the licensee demonstrates that he is qualified and competent to practice nursing, the executive director shall reinstate the renewable nursing license voluntarily surrendered. (3-30-07)

05. Compliance Required. Limited licensure shall be conditioned upon the individual's prompt and faithful compliance with the following: (3-30-07)

a. Satisfactory progress in any required continuing treatment or rehabilitation program. (3-15-02)

b. Regular and prompt notification to the Board of changes in name and address of self or any employer. (7-1-96)

c. Obtaining of performance evaluations prepared by the employer to be submitted at specified intervals and at any time upon request. (7-1-96)

d. Continuing participation in, and compliance with all recommendations and requirements of, the approved treatment or rehabilitation program, and obtaining of reports of progress submitted by the person directing the treatment or rehabilitation program at specified intervals and at any time upon request. (7-1-96)

e. Submission of written self-evaluations and personal progress reports at specified intervals and at any time upon request. (7-1-93)

f. Submission of reports of supervised random alcohol/drug screens at specified intervals and at any time upon request. Participant is responsible for reporting as directed, submitting a sufficient quantity of sample to be tested, and payment for the screening. (7-1-96)

g. Meeting with the Board's professional staff at any time upon request. (7-1-93)

h. Working only in approved practice settings. (7-1-96)

i. Authorization by licensee of the release of applicable records pertaining to assessment, diagnostic evaluation, treatment recommendations, treatment and progress, performance evaluations, counseling, random chemical screens, and after-care at periodic intervals as requested. (7-1-93)

j. Obedience to all laws pertaining to nursing practice, all nursing standards, and all standards, policies and procedures of licensee's employer(s) relating to any of the admitted misconduct or facts as set out in the written statement signed by licensee, or relating to the providing of safe, competent or proper nursing service. (7-1-93)

k. Compliance with other specific terms and conditions as may be required by the executive director. (3-15-02)

06. Summary Suspension - Lack of Compliance. (3-30-07)

a. Summary Suspension. Any failure to comply with the terms and conditions of a limited license shall be deemed to be an immediate threat to the health, safety, and welfare of the public and the executive director shall, upon receiving evidence of any such failure, summarily suspend the limited license. (3-30-07)

i. Summary suspension of a limited license may occur if, during participation in the program, information is received which, after investigation, indicates the individual may have violated a provision of the law or Board Rules governing the practice of nursing. (3-30-07)

ii. Upon summary suspension of a limited license, the executive director shall provide prompt written notice to the licensee stating the reason for the suspension, setting forth the evidence relied upon and notifying the licensee of his right to a hearing upon request at the earliest possible date in accordance with Section 54-1413(3)(a), Idaho Code. (3-30-07)

b. Right to Hearing. An individual whose limited license has been summarily suspended by the executive director may request a hearing regarding the suspension by certified letter addressed to the Board. If the individual fails to request a hearing within twenty (20) days after service of the notice of suspension by the executive director, ~~or after~~ the right to a hearing~~,~~ is waived. ~~i~~If ~~one~~ a hearing is timely requested, after the hearing the Board shall enter an order affirming or rejecting summary suspension of the limited license and enter such further orders revoking, suspending, or otherwise disciplining the nursing license as may be necessary. The above provisions do not limit or restrict the right of Board staff to bring any summary suspension order before the Board for further proceedings, even if the licensee has not requested a hearing. ~~(3-30-07)~~(____)

c. Other Orders. The Board may, for good cause, stay any order of the executive director or may modify the terms and conditions of a limited license as deemed appropriate to regulate, monitor or supervise the practice of any licensee. (3-30-07)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.03.01 - RULES OF THE STATE BOARD OF CHIROPRACTIC PHYSICIANS

DOCKET NO. 24-0301-0702

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-707, 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 Book 2 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 106 through 108.

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 Cherie Simpson at (208) 334-3233.

DATED this 26th day of October, 2007.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., Ste 220
Boise, ID 83709
(208) 334-3233 phone
(208) 334-3945 fax

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-0301-0702***
Rules of the Board of Chiropractic Physicians ***PENDING RULE***

THE FOLLOWING NOTICE 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) 54-707, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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:

Add a scope of practice for clarification, clarify endorsement requirements to consider various timeframes for licensure in another state, increase continuing education requirement to eighteen hours effective January, 2009 to bring the standards up to a national level and allow six hours of the continuing education through distance learning and home study.

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 proposals were distributed to members of the association.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

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 24, 2007.

DATED this 15th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

011. -- 0~~9~~1~~-~~9. (RESERVED).

020. SCOPE OF PRACTICE (RULE 20).
Clinical nutritional methods as referenced in Section 54-704, Idaho Code, include, but are not limited to the clinical use, administration, recommendation, compounding, prescribing, selling, and distributing vitamins, minerals, botanical medicine, herbals, homeopathic, phytonutrients, antioxidants, enzymes, and glandular extracts, durable and non-durable medical goods and devices in all their forms. ( )

022. -- 099. (RESERVED).

100. APPLICATIONS (RULE 100).

01. Application. Applications on forms furnished by the Bureau of Occupational Licenses must be accompanied by an unmounted passport photograph taken within the twelve (12) months preceding the date of application. (3-15-02)

02. Qualifications. (7-1-93)

a. New applicants will meet the following requirements: (7-1-93)

i. National Boards Parts I, II, III, and IV. (7-1-99)

ii. Graduation from a CCE approved college or university. (7-1-93)

iii. Applicants will be required to sign an affidavit swearing under oath that they have fully reviewed and understand and will abide by the Chiropractic Act, Title 54, Chapter 7, Idaho Code, and the Board's Rules, IDAPA 24, Title 03, Chapter 01, "Rules of the State Board of Chiropractic Physicians." (7-1-99)

b. Endorsement applicants will meet the following requirements: (7-1-93)

i. Successful passage of the National Boards Parts ~~*I, II, III*~~ which were in effect at the time of graduation from chiropractic college and physiotherapy. ~~*(7-1-93)*~~( )

ii. If licensed prior to January, 1980, CCE approved college or university not required. If licensed after January, 1980, applicant must have graduated from a CCE approved college or university. (7-1-93)

iii. Five (5) years of consecutive ~~*experience*~~ practice immediately prior to application ~~*and a valid, unrevoked, unsuspended license to practice chiropractic*~~ in another state without discipline. ~~*(7-1-93)*~~( )

iv. National Board Special Purposes Examination for Chiropractors (SPEC). (7-1-99)

v. Applicants will be required to sign an affidavit swearing under oath that they have fully reviewed and understand and will abide by the Chiropractic Act, Title 54, Chapter 7, Idaho Code, and the Board's Rules, IDAPA 24.03.01, "Rules of the State Board of Chiropractic Physicians." (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

300. RENEWAL REQUIREMENT (RULE 300).

01. Active Status. Each renewal application must be accompanied by: (7-1-93)

a. The established fee and; (7-1-93)

b. Certification of having attended and completed a minimum of twelve (12) hours of scientific clinics, forums, or chiropractic study within the previous twelve (12) months, as approved by the Idaho Board of Chiropractic Physicians. Effective January 1, 2009, certification of having attended and completed a minimum of eighteen (18) hours of scientific clinics, forums, or chiropractic study within the previous twelve (12) months, as approved by the board. ~~*(7-1-93)*~~( )

02. Inactive Status. Each application for an Inactive status license must be accompanied by: (3-15-02)

a. The established fee; and (3-15-02)

b. A written request to change a current active license to an inactive license. (3-15-02)

03. Waiving Continued Education Requirements. All continued education requirements will be waived for any year or portion thereof that a licensee maintains an inactive license and is not actively practicing in Idaho. Inactive license renewal notices and licenses will be marked "Inactive." When the licensee desires active status, he must show acceptable fulfillment of continuing educational requirements for the current year and submit a fee equivalent to the difference between the inactive and active renewal fee. The continuing educational requirement and the fees will not be prorated for a partial year. (3-15-02)

301. -- 349. (RESERVED).

350. CONTINUING EDUCATION (RULE 350).
In order to further protect the public health and to facilitate the administration of the Chiropractic Act, the board has formulated the following rules: (7-1-93)

01. Subject Material. The subject material of the continuing education requirement shall be germane to the practice of chiropractic and either; (3-15-02)

a. Sponsored by an approved school of chiropractic; or (3-15-02)

b. Otherwise approved by the board. (3-15-02)

c. "Germane to the practice of chiropractic" shall be limited to Section 54-704(1), Idaho Code. (3-15-02)

02. Verification of Attendance. It shall be necessary for each licensee to maintain verification of attendance by securing authorized signatures or other documentation from the course instructors or sponsoring institution substantiating any and all hours attended by the applicant. This verification shall be maintained by the licensee and provided to the Board upon the request of the Board or its agent. (3-15-02)

03. Distance Learning and Home Study. The board ~~*shall not*~~ may approve ~~*any*~~ a course of study for continuing education credit that does not include the actual physical attendance of the applicant in a face-to-face setting with the course instructor. ~~*Correspondence*~~ Distance Learning or Home Study courses shall ~~*not*~~ be eligible for continuing education credits if sponsored by an approved school of chiropractic or upon approval by the board. Licensee shall not accumulate more than six (6) continuing education hours per renewal period from distance learning or home study. ~~*(3-15-02)*~~( )

04. Requests for Approval. All requests for approval or pre-approval of educational programs must be made to the board in writing, and must be accompanied by a statement that includes the name of the instructor or instructors, the date and time and location of the course, the specific agenda for the course, the number of continuing education credit hours requested, and a statement of how the course is believed to be pertinent to the practice of chiropractic. (3-15-02)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.09.01 - RULES OF THE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

DOCKET NO. 24-0901-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-1604, 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 Book 2 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 132 through 134.

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 Cherie Simpson at (208) 334-3233.

DATED this 26th day of October, 2007.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., Ste 220
Boise, ID 83709
(208) 334-3233 phone
(208) 334-3945 fax

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-0901-0701***
Rules of the Board of Examiners of Nursing Home Administrators ***PENDING RULE***

THE FOLLOWING NOTICE 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) 54-1604, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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:

Change would allow continuing education requirements to be waived for the first renewal of the license and clarify the setting for trainees in the administrators-in-training program.

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 changes are for clarification purposes.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

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 24, 2007.

DATED this 21st day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

200. EDUCATIONAL AND TRAINING REQUIREMENTS (RULE 200).

01. Educational Requirements. In order to be credited toward the educational requirements of the Act, a seminar or course of study must be relevant to nursing home administration as determined by the Board and sponsored by accredited universities or colleges, State or National health related associations, and/or approved by NCERS (National Continuing Education Review Service). (7-1-93)

02. Requirements for License Renewal. The department shall refuse to renew a Nursing Home Administrators license unless the required fee is accompanied by evidence of having met the educational and training requirement set forth in these rules on the form provided for that purpose by the Bureau of Occupational Licenses. (7-1-98)

03. Renewal of License. Applicants for renewal of license shall be required to attend a minimum of twenty (20) clock hours of courses approved under Subsection 200.01 within the preceding twelve-month (12) period. Licensees shall not be required to comply with this requirement during the first year in which they become licensed under this chapter.~~*(7-1-98)*~~( )

04. Credit Received Toward Renewal of License. Credit received toward renewal of license may not be used again toward renewal of license for another license year. (7-1-98)

(BREAK IN CONTINUITY OF SECTIONS)

400. NURSING HOME ADMINISTRATORS-IN-TRAINING (RULE 400).

01. Related Health Care Field. "Related health care field" shall mean a field in health care related to administration. (7-1-93)

02. Trainees. Trainees must work on a full time basis in any capacity in an Idaho licensed nursing home setting. Full time shall be a forty (40) hour per week work schedule with consideration for normal leave taken. Failure to comply with this rule or Section 54-1610, Idaho Code, shall not receive credit as a Nursing Home Administrator-In-Training. ~~*(4-6-05)*~~( )

a. Each trainee shall register with the Board as a Nursing Home Administrator-In-Training (AIT) by submitting an application provided by the Board together with the required fee. The effective date of each AIT program shall be the date the Board approves the application. (3-13-02)

b. Quarterly reports for those trainees employed in a nursing home must reflect that the preceptor of the trainee has instructed, assisted and given assignments as deemed necessary to

fulfill the requirements of Subsection 400.03. (7-1-98)

03. Nursing Home Administrator-in-Training Requirements. A Nursing Home Administrator-in-Training shall be required to train in all phases of nursing home administration including the following: (7-1-93)

a. Resident Care Management. (7-1-98)

b. Personnel Management. (7-1-93)

c. Financial Management. (7-1-93)

d. Environmental Management. (7-1-98)

e. Meeting Regulations and Governing Entities Directives. (7-1-98)

f. Organizational Management. (7-1-98)

g. Completion of a specialized course of study in nursing home long-term health care administration approved by NAB or otherwise approved by the Board. (4-6-05)

04. Facility Administrator. The trainee must spend no less than thirty-two (32) hours a month with the preceptor in a training and/or observational situation in the six (6) areas of nursing home administration as outlined in Subsection 400.03. Quarterly reports must reflect particular emphasis on the six (6) phases of nursing home administration during the time spent in the nursing home. (5-3-03)

05. Preceptor Certification. (7-1-93)

a. A nursing home administrator who serves as a preceptor for a nursing home administrator-in-training must be certified by the Board of Examiners of Nursing Home Administrators. The Board will certify the Idaho licensed nursing home administrator to be a preceptor who: (7-1-98)

i. Is currently practicing as a nursing home administrator and who has practiced a minimum of two (2) consecutive years as a nursing home administrator; and (7-1-98)

ii. Who successfully completes a six (6) clock hour preceptor orientation course approved by the Board. (7-1-93)

b. The orientation course will cover the philosophy, requirements and practical application of the nursing home administrator-in-training program and a review of the six (6) phases of nursing home administration as outlined in Subsection 400.03. (7-1-93)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.11.01 - RULES OF THE STATE BOARD OF PODIATRY

DOCKET NO. 24-1101-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-605, 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 Book 2 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 135 and 136.

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 Cherie Simpson at (208) 334-3233.

DATED this 26th day of October, 2007.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., Ste 220
Boise, ID 83709
(208) 334-3233 phone
(208) 334-3945 fax

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-1101-0701***
Rules of the State Board of Podiatry ***PENDING RULE***

THE FOLLOWING NOTICE 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) 54-605, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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:

Revise examination rules to allow for consideration of the national board examination and the acceptable passing grade, establish a deadline for pending applications, and revise the continuing education courses that the board will accept.

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 changes should not create controversy.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

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 24, 2007.

DATED this 20th day of August, 2007

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

400. LICENSURE BY EXAMINATION (RULE 400).

01. Examination of Applicants. ~~*Examination of applicants shall be conducted by the whole board or by its designated agents or representatives.*~~ All applicants must successfully pass all parts of the national board examination given by the National Board of Podiatric Medical Examiners. ~~*(7-1-97)*~~( )

~~***02. Exam Required for Licensure****. No person shall be granted a license to practice podiatry without first receiving a passing grade on an examination given by the board and consisting of those subjects outlined in Section 54-606, Idaho Code.* *(3-13-02)*~~

~~***03. Exam Dates****. Examinations shall be held at Boise, Idaho, no less than annually and at such times and places as the board shall direct.* *(4-11-06)*~~

0~~*4*~~2. Passing Grade. A passing grade in all subjects examined shall be the grade as established by the National Board of Podiatric Medical Examiners for the examination with a general average of not less than seventy percent (70%). ~~*(5-3-03)*~~( )

~~***05. Failure of Exam****. An applicant failing the examination shall be entitled within six (6) months to a reexamination upon the payment of an additional fee as established in Section 300.* *(3-13-02)*~~

~~***06. Failure of Reexam****. An applicant who fails the examination on two (2) such reexaminations shall exhaust his privilege under his original application.* *(9-28-94)*~~

~~***07. Original Application****. The original application will be considered null and void after a period of two (2) years from date of original application if no license has been issued.* *(7-1-97)*~~

(BREAK IN CONTINUITY OF SECTIONS)

403. -- 4~~*4*~~0~~*9*~~. (RESERVED).

410. ORIGINAL APPLICATION (RULE 410).
The original application will be considered null and void after a period of two (2) years from date of original application if no license has been issued. ( )

411. -- 449. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

700. CONTINUING EDUCATION (RULE 700).

01. Post Graduate Education Requirement for License Renewal. Each podiatrist licensed by the state of Idaho shall attend in each twelve (12) month period preceding the renewal of a license to practice podiatry in Idaho, a minimum of twelve (12) full hours of post-graduate podiatry education courses ~~*approved by the Board*~~. No more than six (6) hours may be home study. Courses must be germane to the practice of podiatry; and ~~*(7-1-98)*~~( )

a. Approved by the Council on Podiatric Medical Education; or ( )

b. Otherwise approved by the Board. ( )

02. Submission of License Renewal Application Form. Each licensed Idaho podiatrist will be furnished a license renewal application form by the Bureau of Occupational Licenses on which each podiatrist shall be required to certify by signed affidavit that compliance with the continuing education requirements has been met and shall submit the renewal application together with the required fees to the Bureau. (3-15-02)

03. Verification of Attendance. It shall be necessary for each licensee to maintain verification of attendance by securing authorized signatures or other documentation from the course instructors or sponsoring institution substantiating any and all hours attended by the applicant. This verification shall be maintained by the licensee and provided to the Board upon the request of the Board or its agent. The Board will conduct random audits to monitor compliance. (3-15-02)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.13.01 - RULES OF THE PHYSICAL THERAPY LICENSURE BOARD

DOCKET NO. 24-1301-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 54-2206, 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 January 3, 2007 Idaho Administrative Bulletin, Vol. 07-1, pages 272 through 275.

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 Cherie Simpson at (208) 334-3233.

DATED this 26th day of October, 2007.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., Ste 220
Boise, ID 83709
(208) 334-3233 phone
(208) 334-3945 fax

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-1301-0701***
Rules of the Physical Therapy Licensure Board ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is November 9, 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(s)54-2206, 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 17, 2007.

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:

These rules are being allowed as per Title 54, Chapter 22. To designate the examinations approved by the Board and to establish the passing scores of those examinations and include the examination as a requirement for licensure.

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

Title 54, Chapter 22 was amended and signed into law in 2006 bringing this board under the Bureau. These rules were not included in the previous rule promulgation and are provided in Tile 54, Chapter 22, Idaho Code.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any negative 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 are being done to comply with Title 54, Chapter 51.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed

rule, contact Cherie Simpson at (208) 334-3233.

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 24, 2007.

DATED this 9th day of November, 2006.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

010. DEFINITIONS (RULE 10).

01. Board. The Physical Therapy Licensure Board. (3-21-07)

02. Bureau. Bureau means the Idaho Bureau of Occupational Licenses as created in section 67-2602, Idaho Code. (3-21-07)

03. Physical Therapist. An individual who meets all the requirements of Title 54, Chapter 22, Idaho Code, holds an active license and who engages in the practice of physical therapy. (3-21-07)

04. Physical Therapist Assistant. An individual who meets the requirements of Title 54, Chapter 22, Idaho Code, holds an active license, and who performs physical therapy procedures and related tasks that have been selected and delegated only by a supervising physical therapist. (3-21-07)

05. Supportive Personnel. An individual, or individuals, who are neither a physical therapist or a physical therapist assistant, but who are employed by and/or trained under the direction of a licensed physical therapist to perform designated non-treatment patient related tasks and routine physical therapy tasks. (3-21-07)

06. Non-Treatment Patient Related Tasks. Actions and procedures related to patient care that do not involve direct patient treatment or direct personal supervision, but do require a level of supervision not less than general supervision, including, but not limited to: treatment area preparation and clean-up, equipment set-up, heat and cold pack preparation, preparation of a patient for treatment by a physical therapist or physical therapist assistant, transportation of patients to and from treatment, and assistance to a physical therapist or physical therapist assistant when such assistance is requested by a physical therapist or physical therapist assistant when safety and effective treatment would so require. (3-21-07)

07. Routine Physical Therapy Tasks. Actions and procedures within the scope of practice of physical therapy, which do not require the special skills or training of a physical therapist or physical therapist assistant, rendered directly to a patient by supportive personnel at the request of and under the direct personal supervision of a physical therapist or physical therapist assistant. (3-21-07)

08. Testing. (3-21-07)

a. Standard methods and techniques used in the practice of physical therapy to gather data about individuals including: (3-21-07)

i. Electrodiagnostic and electrophysiological measurements; (3-21-07)

ii. Assessment or evaluation of muscle strength, force, endurance and tone; (3-21-07)

iii. Reflexes; (3-21-07)

iv. Automatic reactions; (3-21-07)

v. Posture and body mechanics; (3-21-07)

vi. Movement skill and accuracy; (3-21-07)

vii. Joint range of motion and stability; (3-21-07)

viii. Sensation; (3-21-07)

ix. Perception; (3-21-07)

x. Peripheral nerve function integrity; (3-21-07)

xi. Locomotor skills; (3-21-07)

xii. Fit, function and comfort of prosthetic, orthotic, and other assistive devices; (3-21-07)

xiii. Limb volume, symmetry, length and circumference; (3-21-07)

xiv. Clinical evaluation of cardiac and respiratory status to include adequacy of pulses, noninvasive assessment of peripheral circulation, thoracic excursion, vital capacity, and breathing patterns; (3-21-07)

xv. Vital signs such as pulse, respiratory rate, and blood pressure; (3-21-07)

xvi. Activities of daily living; and the physical environment of the home and work place; and (3-21-07)

xvii. Pain patterns, localization and modifying factors; and (3-21-07)

xviii. Photosensitivity. (3-21-07)

b. Specifically excluded are the ordering of electromyographic study, electrocardiography, thermography, invasive vascular study, selective injection tests, or complex

cardiac or respiratory function studies without consultation and direction of a physician. (3-21-07)

09. Functional Mobility Training. Includes gait training, locomotion training, and posture training. (3-21-07)

10. Manual Therapy. Skilled hand movements to mobilize or manipulate soft tissues and joints for the purpose of: (3-21-07)

a. Modulating pain, increasing range of motion, reducing or eliminating soft tissue swelling, inflammation or restriction; (3-21-07)

b. Inducing relaxation; (3-21-07)

c. Improving contractile and non-contractile tissue extensibility; and (3-21-07)

d. Improving pulmonary function. (3-21-07)

11. Physical Agents or Modalities. Thermal, acoustic, radiant, mechanical, or electrical energy used to produce physiologic changes in tissues. (3-21-07)

12. General Supervision. A physical therapist's availability at least by means of telecommunications, which does not require a physical therapist to be on the premises where physical therapy is being provided, for the direction of a physical therapist assistant. (3-21-07)

13. Direct Supervision. A physical therapist's or physical therapist assistant's physical presence and availability to render direction in person and on the premises where physical therapy is being provided. (3-21-07)

14. Direct Personal Supervision. A physical therapist's or physical therapist assistant's direct and continuous physical presence and availability to render direction, in person and on the premises where physical therapy is being provided. The physical therapist or physical therapist assistant must have direct contact with the patient during each session and assess patient response to delegated treatment. (3-21-07)

15. Supervising Physical Therapist. A licensed physical therapist who developed and recorded the initial plan of care and/or who has maintained regular treatment sessions with a patient. Such physical therapist's designation of another licensed physical therapist if the physical therapist who developed and recorded the initial plan of care or maintained regular treatment sessions is not available to provide direction at least by means of telecommunications. (3-21-07)

16. Nationally Accredited School. A school or course of physical therapy or physical therapist assistant with a curriculum approved by: (3-21-07)

a. The American Physical Therapy Association (APTA) from 1926 to 1936; or the APTA Accreditation Commission; or (3-21-07)

b. The Council on Medical Education and Hospitals of the American Medical

Association from 1936 to 1960; or (3-21-07)

c. An Accrediting agency recognized by the U.S. Commissioner of Education, the Council on Postsecondary Accreditation, or both. (3-21-07)

17. **Examination**. The examination shall be the National Physical Therapy Examination (NPTE) administered by Federation of State Boards of Physical Therapy. The examination may also include a jurisprudence examination adopted by the Board. ( )

(BREAK IN CONTINUITY OF SECTIONS)

151. -- 1~~99~~74. (RESERVED).

175. REQUIREMENTS FOR LICENSURE (RULE 175).
An individual shall be entitled to a license upon meeting the following requirements: ( )

01. **Application**. Submission of a complete application establishing that the individual has met the qualifications as set forth in these rules. ( )

02. **Examination**. Submission of proof that the individual has successfully passed the NPTE with a scaled score of at least six hundred (600) and the jurisprudence examination with a score of at least seventy-five percent (75%). ( )

176. -- 199. (RESERVED).

IDAPA 24 - IDAHO BUREAU OF OCCUPATIONAL LICENSES

24.14.01 - RULES OF THE STATE BOARD OF SOCIAL WORK EXAMINERS

DOCKET NO. 24-1401-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-3204, 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 Book 2 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 137 through 143.

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 Cherie Simpson at (208) 334-3233.

DATED this 26th day of October, 2007.

Tana Cory
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BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-1401-0701***
Rules of the Board of Social Work Examiners ***PENDING RULE***

THE FOLLOWING NOTICE 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) 54-3204, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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

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

To clarify supervision of social workers in state and out of state and supervisor registration requirements. Update examination titles and update terminology in public policy and code of professional conduct.

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 changes are necessary to protect the public in regards to qualified supervised experience and code of conduct.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

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 24, 2007.

DATED this 15th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

201. PRACTICE OF SOCIAL WORK.

01. Baccalaureate Social Work. The application of social work theory, knowledge, methods, and ethics to restore or enhance social or psychosocial functioning of individuals, couples, families, groups, organizations, and communities. Baccalaureate social work is a generalist practice that includes assessment, planning, intervention, evaluation, case management, information and referral, supportive counseling, supervision, and consultation with clients. Baccalaureate social work also includes advocacy, education, community organization, and the development, implementation and administration of policies, programs, and activities. Bachelor level social workers are prohibited from performing psychotherapy. (3-20-04)

02. Master's Social Work. The application of social work theory, knowledge, methods and ethics, and the professional use of self to restore or enhance social, psychosocial or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities. Master's social work requires the application of specialized knowledge and advanced practice skills in the areas of assessment, treatment planning, implementation and evaluation, case management, information and referral, supportive counseling, supervision and consultation with clients, advocacy, teaching, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Master level social workers who do not hold clinical licensure may provide psychotherapy only under the supervision of a licensed clinical social worker, psychologist, or psychiatrist and in accordance with an approved supervision plan. (3-20-04)

03. Clinical Social Work. The practice of clinical social work is a specialty within the practice of master's social work and requires the application of specialized clinical knowledge and advanced clinical skills in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions and addictions. Clinical social work is based on knowledge and theory of psychosocial development, behavior, psychopathology, motivation, interpersonal relationships, environmental stress, social systems, and cultural diversity, with particular attention to person-in-environment. It shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work includes, but is not limited to, individual, couples, family and group psychotherapy, and includes independent and private practice. (3-20-04)

04. Private Practice of Social Work. As defined in Section 54-3207, Idaho Code, is that independent practice in which an individual sets up and maintains responsibility for the contractual conditions of payment with clients, agencies, or institutions. (5-3-03)

05. Employment of a Social Worker. A social worker employed directly by a physician, psychologist or other social worker, or by a public or private agency, institution, hospital, nursing home, rehabilitation center, or any similar facility, is not to be considered within the definition of an independent practitioner. Furthermore, a social worker who contracts with an

agency or institution that assumes full responsibility for and supervises the services provided to clients is not considered to be a private practitioner. (5-3-03)

06. Supervision. Supervised experience shall be required for both independent practice status and clinical licensure. Consultative-teaching supervision is directed toward enhancement and improvement of the individual's social work values, knowledge, methods, and techniques. A total of three thousand (3,000) hours of supervised social work experience accumulated in not less than two (2) years is required. Actual supervisor contact shall be face-to-face and provided by a qualified and experienced professional working in the same area of practice and must occur on a regular and on-going basis and consist of a minimum of one hundred hours (100) hours. Ratio of supervisor/supervisee shall not exceed two (2) social workers to one (1) supervisor per hour of supervision. Group supervision totaling no more than fifty (50) hours will be allowed for groups of no more than six (6) persons and the allowable credit shall be prorated at the two to one (2 to 1) ratio (total session minutes divided by total supervisees multiplied by two (2) equals maximum allowable credit per supervisee for the session. i.e. an individual attending a one (1) hour group supervisory session consisting of six (6) supervisees shall be allowed twenty (20) minutes of group supervision credit). Supervisors must hold a degree in social work and a current license in good standing, except as noted in Subsection 201.0~~8~~6.c.
~~*(4-11-06)*~~(____)

a. Supervision of baccalaureate social workers pursuing licensure as independent practitioners must be provided by a licensed social worker approved to provide independent practice at the baccalaureate, masters, or clinical level. (3-20-04)

b. Supervision of masters social workers pursuing licensure as independent practitioners must be provided by a licensed social worker approved to provide independent practice at the masters or clinical level. (5-3-03)

c. Supervision of social workers pursuing licensure as clinical level practitioners must be provided by either a licensed clinical social worker who is registered as a supervisor, a licensed clinical psychologist, a person licensed to practice medicine and surgery who practices in the area of psychiatry, a licensed clinical professional counselor registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists or a licensed marriage and family therapist registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists and must focus on clinical social work as defined. No less than fifty percent (50%) of supervised experience must be provided by a licensed clinical social worker registered as a supervisor. A social worker pursuing licensure at the clinical level must document one thousand seven hundred fifty (1,750) hours of direct client contact of the required three thousand (3,000) hours in clinical social work as defined.
~~*(3-14-05)*~~(____)

d. Supervision reports shall be submitted from each supervisor directly to the Board within thirty (30) days following each six (6) month period. Failure of the supervisor to submit the required reports in a timely manner may result in the supervisor being restricted by the Board from providing further supervision. (3-20-04)

07. Supervised Practice Required. To be eligible for licensure as an independent practitioner a candidate must: (5-3-03)

a. Meet the requirements set forth in Subsection 201.0~~8~~6; ~~(3-20-04)~~(____)

b. Develop a plan for supervision that must be approved by the Board prior to commencement of supervision. Prior to a change in supervisors, the supervisee must notify the Board and the change must be approved by the Board prior to the commencement of supervision by the new supervisor; and (5-3-03)

c. Not have more than two (2) supervisors at any given time. (5-3-03)

08. Out-of-State Supervised Experience. The Board may consider supervised experience obtained outside the state of Idaho submitted for Idaho license purposes. Supervised experience must be provided by a licensed clinical social worker, licensed marriage and family therapist, licensed clinical psychologist, or a person licensed to practice medicine and surgery who practices in the area of psychiatry. No less than fifty percent (50%) of supervised experience must be provided by a licensed clinical social worker. The applicant must meet the other requirements of supervised practice as set forth in these rules. (____)

202. SOCIAL WORK SUPERVISOR REGISTRATION (RULE 202).
Effective January 1, 2007, Idaho licensed social workers shall be registered with the Board in order to provide postgraduate supervision for those individuals pursuing licensure in Idaho as a clinical social worker. (4-11-06)

01. Requirements for Registration. (3-14-05)

a. Document at least two (2) years experience as a licensed clinical social worker. (4-11-06)

b. Have not been the subject of any disciplinary action for five (5) years prior to application for registration. (3-14-05)

c. Document fifteen (15) contact hours of education in clinical supervisor training as approved by the Board. ~~(4-11-06)~~(____)

02. Registration. A supervisor applicant shall submit to the Bureau a completed application form as approved by the board. (3-14-05)

a. Upon receipt of a completed application verifying compliance with the requirements for registration as a supervisor, the applicant shall be registered as a supervisor. (3-14-05)

b. A supervisor's registration shall be valid only so long as the individual's clinical social worker license remains current and in good standing. (3-14-05)

(BREAK IN CONTINUITY OF SECTIONS)

350. EXAMINATIONS, ENDORSEMENT, AND BOARD MEETINGS (RULE 350). Examinations will be conducted by the board for qualified applicants for social work licensing and board meetings will be held to conduct other business. Applications for examination may be reviewed and approved by a designated Board member upon determination that the applicant meets the qualifications for examination. Approval to sit for examination does not obligate the Board to issue a license if it is later determined that the applicant does not meet the requirements for licensure. (3-20-04)

01. Board Meetings. Board meetings will be held at least three (3) times each year at such times and places as the board deems necessary. (5-3-03)

02. Exam Utilized. The Board utilizes the uniform, nationally standardized examination of the Association of Social Work Boards (ASWB). (5-3-03)

a. Bachelor level candidates shall be required to successfully pass the ~~*basic*~~ bachelor's examination. ~~*(5-3-03)*~~( )

b. Masters level candidates shall be required to successfully pass the ~~*intermediate*~~ master's examination. ~~*(5-3-03)*~~( )

c. Clinical level candidates shall be required to successfully pass the clinical examination. (5-3-03)

03. Dates of Exams. Examination at all levels of social work licensing will be conducted on dates established for national administration. (7-1-93)

04. Graduation Date to Qualify for Exam. Candidates for examination who can satisfy the board that they will be graduating at the end of the spring, summer or fall terms of any given year, may qualify for examination at the established testing period immediately preceding the date of graduation. (5-24-95)

05. Exemption from Exam. An applicant who has been tested for licensure utilizing an acceptable examination will be exempt from the Idaho examination if the applicant received a converted score of seventy (70) based upon a criterion reference examination. (7-1-93)

06. Endorsement. The Board may grant a license to any person who submits a completed application on a form approved by the Board together with the required fees and who: (5-3-03)

a. Holds a current, active social work license, at the level for which a license is being sought, issued by the authorized regulatory entity in another state or country, the certification of which must be received directly by the Board from the issuing agency; and (3-20-04)

b. Has not been disciplined within the last five (5) years, had a license revoked, suspended, restricted, or otherwise sanctioned by any regulatory entity and has never voluntarily

surrendered a license; and (5-3-03)

c. Is of good moral character and has not been convicted, found guilty, or received a withheld judgment or suspended sentence for any felony; and (5-3-03)

d. Has successfully passed an examination, as referenced in Subsection 350.02, or an examination provided by the Professional Examination Service (PES) at the clinical social worker and social worker level or the Education Testing Service (ETS) examination; and (5-3-03)

e. Has certified under oath to abide by the laws and rules governing the practice of social work in Idaho and the code of professional conduct. (5-3-03)

(BREAK IN CONTINUITY OF SECTIONS)

450. STATEMENT OF PUBLIC POLICY AND CODE OF PROFESSIONAL CONDUCT (RULE 450).
The profession of social work is dedicated to serving people; the professional relationship between social workers and clients thus shall be governed by the highest moral and ethical values. The client is in a vulnerable role that extends beyond the time frame of actual services. In both social and professional interactions, this vulnerability shall be taken into consideration whether the person is currently or has been a client. Following is the Code of Professional Conduct: (5-24-95)

01. The Social Worker's Ethical Responsibility to Clients. (7-1-93)

a. For the purpose of this Code of Professional Conduct, a client is anyone for whom the social worker provides social work services directly or indirectly through consultations, staffings, or supervision with other professionals. (7-1-93)

b. The social worker shall not commit fraud nor misrepresent services performed. (7-1-93)

c. The social worker shall not solicit the clients of an agency for which they provide services for his private practice. (7-1-93)

d. The social worker shall not divide a fee or accept or give anything of value for receiving or making a referral. (7-1-93)

e. The social worker shall provide clients with accurate and complete information regarding the extent and nature of the services available to them. (7-1-93)

f. The social worker shall terminate service to clients, and professional relationships with them, when such service and relationships are no longer required or in which a conflict of interest arises. (7-1-93)

g. A social worker shall not violate a position of trust by knowingly committing any

act detrimental to a client. (7-1-93)

h. A social worker shall not exploit their professional relationships with clients (or former clients), supervisees, supervisors, students, employees, or research participants, sexually or otherwise. Social workers shall not condone or engage in sexual harassment. Sexual harassment is defined as deliberate or repeated comments, gestures, or physical contacts of a sexual nature that are unwelcomed by the recipient. (7-1-93)

i. A social worker shall not engage in sexual acts with a client or with a person who has been a client within the past three (3) years. A social worker shall not provide social work services to a person with whom he/she has had a sexual relationship. (7-1-93)

02. The Social Worker's Conduct and Comportment as a Social Worker. (7-1-93)

a. In providing services, a social worker shall not discriminate on the basis of age, ~~*sex*~~ gender, race, color, religion, national origin, mental status, ~~*or*~~ physical ~~*handicap*~~ disability, social or economic status, political belief, or any other preference or personal characteristic, condition or status. ~~*(7-1-93)*~~( )

b. Social workers shall not undertake any activity in which their personal problems are likely to lead to inadequate performance or harm to a client, colleague, student, or research participant. If engaged in such activity when they become aware of their personal problems, they shall seek competent professional assistance to determine whether they should suspend, terminate, or limit the scope of their professional activities. (7-1-93)

c. A social worker shall not ~~*provide social work service*~~ practice while ~~*under the influence of*~~ impaired by medication, alcohol, ~~*or other mind-altering or mood-altering*~~ drugs, ~~*which impair delivery of services*~~ or other chemicals. A social worker shall not practice under a mental or physical condition that impairs the ability to practice safely . ~~*(7-1-93)*~~( )

d. A social worker shall not repeatedly fail to keep scheduled appointments. (7-1-93)

e. The social worker who anticipates the termination or interruption of service to clients shall notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences. (7-1-93)

f. The social worker shall attempt to make appropriate referrals as indicated by the client's need for services. (7-1-93)

g. A social worker shall obtain the client's or legal guardian's informed written consent when a client is to be involved in any research project. A social worker shall explain the research, including any implications. (7-1-93)

h. The social worker shall obtain informed consent of clients before taping, recording, or permitting third party observation of their activities. (7-1-93)

i. A social worker shall safeguard information given by clients in providing client services. Except when required by law or judicial order, a social worker shall obtain the client's

informed written consent before releasing confidential information from the setting or facility except for compelling reasons defined as but not limited to: (7-1-93)

i. Consultation with another professional on behalf of the client thought to be dangerous to self or others; (7-1-93)

ii. Duty to warn pursuant to Chapter 19, Title 6, Idaho Code; (5-24-95)

iii. Child abuse and sexual molestation pursuant to Chapter 16, Title 16, Idaho Code; and (5-24-95)

iv. Any other situation in accordance with statutory requirements. (7-1-93)

j. A social worker shall report any violation of the law or rules, including Code of Professional Conduct, by a person certified under Chapter 32, Title 54, Idaho Code. (7-1-93)

03. Competent Practice for Social Workers. All social workers shall practice in a competent manner consistent with their level of education, training and experience. (3-20-04)

a. A social worker shall only represent himself and practice within the boundaries of his education, training, licensure level, supervision, and other relevant professional experience. (3-20-04)

b. A social worker shall only practice within new areas or use new intervention techniques or approaches after engaging in appropriate study, training, consultation, or supervision. (3-20-04)

c. A social worker shall exercise careful judgement, when generally recognized standards do not exist with respect to an emerging area of practice, and take responsible steps to ensure the competence of his practice. (3-20-04)

04. The Advertising Rules for Social Workers. No social worker shall disseminate or cause the dissemination of any advertisement or advertising which is any way fraudulent, false, deceptive or misleading. Any advertisement or advertising shall be deemed by the board to be fraudulent, false, deceptive, or misleading if it: (7-1-93)

a. Contains a misrepresentation of fact; or (7-1-93)

b. Is misleading or deceptive because in its content or in the context in which it is presented it makes only a partial disclosure of relevant facts. More specifically, it is misleading and deceptive for a social worker to advertise free services or services for a specific charge when in fact the social worker is transmitting a higher charge for the advertised services to a third party payor for payment or charges the patient or a third party. It is misleading and deceptive for a social worker or a group of social workers to advertise a social work referral service or bureau unless the advertisement specifically names each of the individual social workers who are participating in the referral service or bureau. (7-1-93)

c. Creates false or unjustified expectations of beneficial treatment or successful

outcomes; or (7-1-93)

d. Fails to identify conspicuously the social worker or social workers referred to in the advertising as a social worker or social workers; or (7-1-93)

e. Contains any representation or claims, as to which the social worker, referred to in the advertising, fails to perform; or (7-1-93)

f. Contains any representation which identifies the social worker practice being advertised by a name which does not include the terms "social worker," "social work," or some easily recognizable derivation thereof; or (7-1-93)

g. Contains any representation that the practitioner has received any license or recognition by the state of Idaho or its authorized agents, which is superior to the license and recognition granted to any social worker who successfully meets the licensing requirements of Chapter 32, Title 54, Idaho Code; or (7-1-93)

h. Appears in any classified directory, listing, or compendium under a heading, which when considered together with the advertisement, has the capacity or tendency to be deceptive or misleading with respect to the profession or professional status of the social worker; or (7-1-93)

i. Contains any other representation, statement, or claim which is misleading or deceptive. (7-1-93)

IDAPA 24 - IDAHO BUREAU OF OCCUPATIONAL LICENSES

24.16.01 - RULES OF THE STATE BOARD OF DENTURITRY

DOCKET NO. 24-1601-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-3309, 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 Book 2 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 152 through 155.

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 Cherie Simpson at (208) 334-3233.

DATED this 26th day of October, 2007.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., Ste 220
Boise, ID 83709
(208) 334-3233 phone
(208) 334-3945 fax

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-1601-0701***
Rules of the State Board of Denturitry ***PENDING RULE***

THE FOLLOWING NOTICE 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) 54-3309, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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

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

To limit the length of an internship and create a standard for advertisements to ensure public safety.

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 changes should not be controversial.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

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 24, 2007.

DATED this 23rd day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

300. INTERNSHIP (RULE 300).

01. Requirements and Conditions for Internship. (3-10-00)

a. To be eligible for internship the applicant must have completed: (3-10-00)

i. The educational requirements set forth in Section 54-3310(b), Idaho Code; or (3-10-00)

ii. Have denturitry experience of three (3) years within the five (5) years immediately preceding application. (3-10-00)

b. Where an internship is established based on experience, the internship is valid only while the intern is actively pursuing completion of Idaho licensure requirements. (3-10-00)

c. Application shall be made on forms provided by the Bureau of Occupational Licenses and shall: (3-10-00)

i. Document the location of practice; (3-10-00)

ii. Include the name and address of the supervising denturist or dentist; (3-10-00)

iii. Include a sworn or affirmed statement by the supervising denturist or dentist; (3-10-00)

iv. Include a sworn or affirmed statement by the supervisor accepting supervision of the intern; (3-10-00)

v. Include a sworn statement by applicant that he is knowledgeable of law and rules and will abide by all requirements of such law and rules; and (3-10-00)

vi. Include such other information necessary to establish applicant's qualifications for licensure as a denturist and establish compliance with pre-intern requirements. (3-10-00)

d. Two (2) years of internship under the supervision of a licensed denturist shall be completed in not less than twenty-four (24) months and shall not exceed thirty (30) months except as approved by the board. ( )

02. Internship Equivalency. A person shall be considered to have the equivalent of two (2) years internship under a licensed denturist who has met and verifies one (1) of the following within the five (5) years immediately preceding application: (3-10-00)

a. Two (2) years internship as a denture lab technician under a licensed dentist; or (3-10-00)

b. Two (2) years in the military as a denture lab technician; or (3-10-00)

c. Three (3) years experience as a denturist under licensure in another state or Canada. (3-10-00)

03. Internship Not to Exceed One Year. Internship not to exceed one (1) year acquired through a formal training program in an acceptable school will be accepted toward the two (2) year required internship for licensure. (7-1-93)

04. Training Requirements. Each year of required internship shall consist of two thousand (2,000) clock hours of training and performance of the following minimum procedures for licensure. (7-1-93)

a. Procedures shall include all steps required in constructing a finished denture but are not limited to the following: (7-1-93)

i. Patient charting -- thirty-six (36) minimum. (7-1-93)

ii. Operatory sanitation -- thirty-six (36) minimum. (7-1-93)

iii. Oral examination -- thirty-six (36) minimum. (7-1-93)

iv. Impressions, preliminary and final (pour models, custom trays) -- thirty-six (36) minimum. (7-1-93)

v. Bite registrations -- twelve (12) minimum. (7-1-93)

vi. Articulations -- twelve (12) minimum. (7-1-93)

vii. Set ups -- twelve (12) minimum. (7-1-93)

viii. Try ins -- twelve (12) minimum. (7-1-93)

ix. Processing (wax up, flask-boil out, packing, grind-polish) -- thirty-six (36) minimum. (7-1-93)

x. Delivery-post adjustment -- thirty-six (36) minimum. (7-1-93)

b. Processed relines (one (1) plate = one (1) unit) -- twenty-four (24) units. (7-1-93)

c. Tooth repairs -- forty-eight (48) minimum. (7-1-93)

d. Broken or fractured plates or partials -- forty-eight (48) minimum. (7-1-93)

05. Reporting Requirements. Interns must file reports, attested to by the supervisor, with the board on forms provided by the Bureau of Occupational Licenses on a monthly basis and recapped at termination or completion of the training. (7-1-93)

06. Denture Clinic Requirements. Denture clinic requirements for approved internship training: (7-1-93)

a. There shall be not more than one (1) internee per licensed denturist or dentist who is practicing at the clinic on a full time basis. (7-1-93)

b. There shall be a separate work station in the laboratory area for each intern with standard equipment, i.e. lathe, torch and storage space. The intern shall provide necessary hand tools to perform the duties of the denture profession. Use of the operatory facilities and other equipment will be shared with the intern. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

450. STANDARDS OF CONDUCT AND PRACTICE (RULE 450).

01. Sanitation. (7-1-93)

a. There shall be three (3) separate rooms; a reception room, and operatory room and a laboratory. (7-1-93)

b. The operatory room shall have hot and cold running water, basin with approved disposal system; disinfectant soap; single-use towels, a cuspidor with running water and a closed waste receptacle. (8-24-94)

c. The laboratory room shall have hot and cold running water, and basin with approved disposal system. (8-24-94)

d. There shall be a method of sterilization and disinfection evident and in use to insure the protection of the public. (8-24-94)

e. All floors, walls, ceiling and benches shall be kept in a sanitary condition at all times. (8-24-94)

f. Every patient shall have a separate and clean bib and a disposable cup. (7-1-93)

g. Every denturist shall wear a clean and professional garment. (7-1-93)

h. The hands of every denturist shall be washed in the presence of every patient with germicidal or antiseptic soap and water. Every denturist shall wear disposable gloves. (8-24-94)

i. Adequate and conveniently located toilet facilities with hot and cold running water, basin with approved disposal system, soap and single use towels will be provided within the building. (8-24-94)

j. All denturist offices shall be open to inspection anytime during the business hours to inspection by the board or its agents. (7-1-93)

k. All telephones must have emergency phone numbers placed on the telephone. (7-1-93)

02. Office Standards. (7-1-93)

a. Denturists shall take care to use proper sterilization and sanitation techniques in all phases of their work. (7-1-93)

b. A complete record of each patient shall be kept. (7-1-93)

c. All teeth and materials used shall meet ADA standards. (7-1-93)

03. Advertisements. ( )

a. No denturist shall disseminate or cause the dissemination of any advertisement or advertising which is any way fraudulent, false, deceptive or misleading. ( )

0~~3~~4. General Conditions. (7-1-93)

a. Conditions deemed by investigators to be a menace to the public health will be brought to the attention of the board for consideration and immediate action. (7-1-93)

b. These Standards of Conduct and Practice shall be conspicuously posted in every licensed denturist's place of business. (7-1-93)

IDAPA 24 - IDAHO BUREAU OF OCCUPATIONAL LICENSES

24.17.01 - RULES OF THE IDAHO STATE BOARD OF ACUPUNCTURE

DOCKET NO. 24-1701-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-4705, 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 Book 2 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 156 through 158.

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 Cherie Simpson at (208) 334-3233.

DATED this 26th day of October, 2007.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., Ste 220
Boise, ID 83709
(208) 334-3233 phone
(208) 334-3945 fax

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-1701-0701***
Rules of the Idaho State Board of Acupuncture ***PENDING RULE***

THE FOLLOWING NOTICE 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) 54-4705, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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 change will define accredited college or university and clarify requirements for certification due to statute changes during the 2007 legislative session.

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 clarification is due to statute changes during the 2007 legislative session.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

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 24, 2007.

DATED this 15th day August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

010. DEFINITIONS (RULE 10).

01. Board. The State Board of Acupuncture as prescribed in Section 54-4704, Idaho Code. (3-10-00)

02. Technician Certificate. The category of license granted to a qualified applicant who meets the requirements pursuant to Section 54-4708, Idaho Code. (3-30-01)

03. Certification. The category of license granted to a qualified applicant who meets the requirements pursuant to Section 54-4707, Idaho Code. (3-30-01)

04. License. Any license, certification or technician certificate issued to a qualified applicant pursuant to IDAPA 24.17.01, "Rules of the State Board of Acupuncture," promulgated by the Board, permitting said applicant to practice acupuncture in the state of Idaho. (3-10-00)

05. Practitioner. A person to whom a license, certification or technician certificate has been issued pursuant to Title 54, Chapter 47, Idaho Code. (3-30-01)

06. Licensure/Licensed. The category of license granted to a qualified applicant who meets the requirements pursuant to Section 54-4706, Idaho Code. (3-30-01)

07. Approved Acupuncture Program. A formal full-time acupuncture educational program that has met the standards of the Accreditation Commission for Acupuncture and Oriental Medicine or an equivalent educational body. An acupuncture program may be established as having satisfied this requirement by obtaining: (3-30-01)

a. Accreditation; or (3-30-01)

b. Candidacy for accreditation; or (3-30-01)

c. An equivalent evaluation performed by a private, state government, or foreign government agency recognized for that purpose by the NCCAOM (National Certification Commission for Acupuncture and Oriental Medicine) Eligibility Committee. (3-30-01)

08. Didactic Course Work. Educational instruction in acupuncture that is physically obtained in a classroom or laboratory setting, and when such instruction is obtained from, and in the presence of, a person credentialed as a qualified educator of acupuncture. (3-30-01)

09. Clinical Practice. Practical experience in acupuncture that is physically obtained in a health care facility in order to meet the minimum requirements for licensure or certification. (3-30-01)

10. Bureau. The Bureau of Occupational Licenses as prescribed in Sections 54-4705 and 67-2602, Idaho Code. (5-3-03)

11. Accredited College or University. An accredited college or university is a college or university accredited by an accrediting organization approved by the U.S. Department of Education. ( )

(BREAK IN CONTINUITY OF SECTIONS)

200. QUALIFICATIONS FOR LICENSURE (RULE 200).

01. Requirements for Licensure. Applicants for licensure shall submit a complete application, required fee, and official certified documentation of either: (3-30-01)

a. Certification from NCCAOM; or (5-3-03)

b. Graduation from an approved formal full-time acupuncture program of at least one thousand seven hundred twenty-five (1,725) hours of entry-level acupuncture education which includes a minimum of one thousand (1000) hours of didactic course work and five hundred (500) clinical hours practice; and (3-30-01)

c. Successful completion of an acupuncture internship, or other equivalent experience as approved by the Board; and (3-30-01)

d. Receipt of a passing grade on an NCCAOM Acupuncture certification examination; or (3-30-01)

e. Other demonstration of proficiency as uniformly required by the Board for other similarly qualified applicants for licensure; and (3-30-01)

f. Successful completion of a Blood Borne Pathogen course and comprehensive examination that incorporates clean needle techniques and OSHA procedures and requirements. (3-30-01)

02. Requirements for Certification. Applicants for certification shall submit a complete application, required fee and official certified documentation of either: (3-30-01)

a. Successful passage of an examination or other demonstration of proficiency as approved by the board; and ( )

~~a~~b. Successful completion of the requirements for full membership of the American Academy of Medical Acupuncture~~ *or fellowship of the International Academy of Medical Acupuncture, Inc.*~~; or ~~*(3-30-01)*~~( )

c. Possess a doctoral degree in chiropractic, dentistry, podiatric medicine, or

naturopathic medicine from a college or university accredited by an organization approved by the U.S. Department of Education or Idaho State Board of Education; and ( )

~~*b*~~**d.** Successful completion of a minimum of one hundred (100) hours of didactic course work, two hundred (200) hours of practice as a certified technician over a one (1) year period, twenty-five (25) case studies; and (3-30-01)

~~*c*~~**e.** Receipt of a passing grade on a board approved examination that measures minimum competency; ~~*or*~~ and ~~*(3-30-01)*~~( )

~~***d.*** *Other demonstration of proficiency as uniformly required by the Board for other similarly qualified applicants for certification; and* *(3-10-00)*~~

~~*e*~~**f.** Successful completion of a Blood Borne Pathogen course and comprehensive examination that incorporates clean needle techniques and OSHA procedures and requirements. (3-30-01)

03. Requirements for Acupuncture Technician Certificate. Applicants for Acupuncture technician Certificate shall submit a complete application, required fee, and official certified documentation of either: (3-30-01)

a. Successful completion of the requirements for clinical technician certificate from the International Academy of Medical Acupuncture, Inc.; or (3-10-00)

b. Successful completion of a minimum of one hundred (100) hours of didactic course work within one (1) academic year; and (3-30-01)

c. Successful completion of a Blood Borne Pathogen course and comprehensive examination that incorporates clean needle techniques and OSHA procedures and requirements; and (3-30-01)

d. Receipt of a passing grade on a board approved examination leading to an Acupuncture Technician Certificate, or other demonstration of proficiency as may be uniformly required for other similarly qualified applicants as approved by the Board. (3-30-01)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.23.01 - RULES GOVERNING THE IDAHO BOARD OF SPEECH AND HEARING SERVICES

DOCKET NO. 24-2301-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-2910, 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 Book 2 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 170 through 173.

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 Cherie Simpson at (208) 334-3233.

DATED this 26th day of October, 2007.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
1109 Main St., Ste 220
Boise, ID 83709
(208) 334-3233
(208) 334-3945 fax

BUREAU OF OCCUPATIONAL LICENSES ***Docket No. 24-2301-0701***
Rules of the Board of Speech and Hearing Services ***PENDING RULE***

THE FOLLOWING NOTICE 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) 54-2910, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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

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

To clarify qualifications for Audiologists, Speech-Language Pathologists, Speech-Language Pathologist Aides, Speech-Language Pathologist Assistants, and Hearing Aid Dealer and Fitters and to clarify personal contact by supervisors for provisional permit holders.

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 these rules will clarify the laws pertaining to Speech and Hearing Services.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 334-3233.

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 24, 2007.

DATED this 23rd day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

201. -- 2~~9~~09. (RESERVED).

210. QUALIFICATIONS FOR AUDIOLOGIST LICENSURE (RULE 210).
All applicants for licensure as an audiologist must comply with the following education, experience, and examination requirements in addition to completion of an application as set forth in Section 150: ( )

01. Graduate Program Requirement. A master's or doctoral degree with emphasis in audiology or not less than seventy-five (75) semester credit hours of post-baccalaureate study that culminates in a doctoral degree from a nationally accredited school for audiology. ( )

02. Examination. Pass an examination given by PRAXIS or other examination as may be approved by the Board. ( )

03. Experience. Meet the supervised academic clinical practicum and supervised postgraduate experience approved by the Board. ( )

211. -- 219. (RESERVED).

220. QUALIFICATIONS FOR SPEECH-LANGUAGE PATHOLOGIST LICENSURE (RULE 220).
All applicants for licensure as a speech-language pathologist must comply with the following education, experience, and examination requirements in addition to completion of an application as set forth in Section 150: ( )

01. Graduate Program Requirement. A master's or doctoral degree from a nationally accredited school of speech-language pathology with a curriculum approved by the Board. ( )

02. Examination. Pass an examination in speech-language pathology given by PRAXIS or other examination as may be approved by the Board. ( )

03. Experience. Meet the supervised academic clinical practicum and supervised postgraduate experience approved by the Board. ( )

221. -- 229. (RESERVED).

230. QUALIFICATIONS FOR SPEECH-LANGUAGE PATHOLOGIST AIDE LICENSURE (RULE 230).
All applicants for licensure as a speech-language pathologist aide must comply with the following education, experience, and examination requirements in addition to completion of an application as set forth in Section 150: ( )

01. Education Program Requirement. A baccalaureate degree from a nationally accredited school of speech-language pathology with a curriculum approved by the Board. ( )

02. Examination. Pass an examination in speech-language pathology aide as may

approved by the Board. ( )

03. Supervision. A speech-language pathologist aide shall only work under the supervision of a speech-language pathologist. ( )

231. -- 239. (RESERVED).

240. QUALIFICATIONS FOR SPEECH-LANGUAGE PATHOLOGIST ASSISTANT LICENSURE (RULE 240).
All applicants for licensure as a speech-language pathologist assistant must comply with the following education and examination requirements in addition to completion of an application as set forth in Section 150: ( )

01. Education Program Requirement. An associate's degree from a nationally accredited school of speech-language pathology with a curriculum approved by the Board. ( )

02. Examination. Pass an examination in speech-language pathology assistant as may be approved by the Board. ( )

03. Supervision. A speech-language pathologist assistant shall only work under the supervision of a speech-language pathologist. ( )

241. -- 249. (RESERVED).

250. QUALIFICATIONS FOR HEARING AID DEALER AND FITTER LICENSURE (RULE 250).
All applicants for licensure as a hearing aid dealer and fitter must comply with the following education, experience, and examination requirements in addition to completion of an application as set forth in Section 150: ( )

01. Education Requirement. A high school diploma or successful passage of the General Educational Development diploma (GED). ( )

02. Examination. Pass an examination approved by the Board. ( )

251. -- 299. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

450. PROVISIONAL PERMIT (RULE 450).
The Board may issue a provisional permit to allow a person to engage in the practice of audiology or speech-language pathology while completing either the required postgraduate experience or a comparable experience as part of a doctoral program in audiology. The Board may issue a provisional permit to allow a person to engage in fitting and dealing hearing aids pursuant to rules adopted by the Board. The holder of a provisional permit may practice only while under the supervision of a person fully licensed under this chapter. (3-30-06)

01. Adequate Personal Contact -- Requirements. (3-30-06)

a. The supervisor and provisional permit holder must make contact in person each work day to review any assignments, client contacts, diagnoses, therapies, and hearing aid fittings for the first sixty (60) days of employment. ~~*A minimum of sixty (60) contacts that must be completed within the first six (6) months of such supervision.*~~ The nature of the supervision and contact must allow for immediate feedback and includes audio/visual, in person, or telephone contacts. ~~*(3-30-06)*~~( )

b. Contact in person described in Subsection 450.01.a., after the first sixty (60) days of employment must be made no less than once in each calendar week throughout the ~~*entire*~~ remaining period of the permit. ~~*(3-30-06)*~~( )

c. In the event a permit holder fails the licensing examination two (2) consecutive times, and is eligible to maintain a permit, the supervisor and permit holder must reinstate contact in person each work day as set forth in Subsection 450.01.a. (3-30-06)

d. All client and supervisor contacts shall be recorded in the permit holder's quarterly report. (3-30-06)

02. Supervisor -- Responsibilities -- Restrictions. (3-30-06)

a. The supervisor shall be familiar with Section 54-2908, Idaho Code. (3-30-06)

b. The supervisor shall be responsible for all practice and the ethical conduct of each permit holder under supervision. (3-30-06)

c. A supervisor may not supervise more than one (1) permit holder at a time. (3-30-06)

d. The supervisor and the permit holder shall be required to work within the same facility. (3-30-06)

e. The supervisor shall provide the permit holder with adequate training and client contact necessary to prepare for the required examination. (3-30-06)

f. The supervisor shall record with the Board a plan of training that encompasses all ten sections covered in the license examination. The plan must be accepted and approved by the Board or its agent prior to issuance of the permit. The supervisor shall document, by the quarterly report, the permit holder's progress. (3-30-06)

g. A supervisor may terminate his supervision of a permit holder by a written notice to the Bureau and the permit holder by certified mail at least ten (10) calendar days prior to the termination. (3-30-06)

03. Application -- Quarterly Reports. (3-30-06)

a. Application for permit shall include completed application, examination fee, permit fee, supervisor statement and plan of training and supervision. (3-30-06)

b. A permit shall not be valid unless an unrevoked statement accepting supervisory responsibility by a qualified licensee is on file with the Bureau. Upon termination of supervision, a new permit may be applied for in accordance with these rules, provided that the expiration date of the new permit is adjusted to not exceed the date of the third licensure examination following the original application. (3-30-06)

c. Eighteen (18) months is the maximum time allowed for any combination of new or renewed permits. (3-30-06)

d. Every permit holder must submit a quarterly report of his activities on forms furnished by the Bureau together with supplemental attachments as may be necessary, attested to and signed by the permit holder and the supervisor of record. All sales or fittings made by the permit holder will be indicated on the quarterly report forms supplied by the Bureau. Supplemental attachments to be submitted with this form include: (3-30-06)

i. Log of client and supervisor contacts as specified in Subsection 450.01.d. (3-30-06)

ii. Supervisor's statement of completion of training assignments by permit holder as specified in Subsection 450.02.f. (3-30-06)

iii. Copy of test results for all persons tested by the permit holder whether or not a sale occurred. (3-30-06)

iv. Copy of hearing aid order for all fittings including specifications of instruments ordered. (3-30-06)

e. Quarterly reports are due on or before April 10th, July 10th, October 10th and January 10th for the three (3) months preceding the month due. If the permit has not been in effect for the entire quarter, the report is due for that portion of the quarter in which the permit was in effect. If quarterly reports are not received by the specified due date, the permit will be revoked. A new permit may be applied for in accordance with Subsection 450.03.a. (3-30-06)

04. Exemptions. (3-30-06)

a. A permit holder who possesses the Certificate of Clinical Competence in Audiology from American Speech-Language-Hearing Association (ASHA) or who is Board Certified by National Board for Certification in Hearing Instrument Sciences (NBC-HIS) shall be exempt from Subsections 450.01.a., 450.02.d., and 450.02.f. from the date of issuance of the permit until the date of the next offered licensing examination. (3-30-06)

b. Failure of the licensing examination or failure to take the next offered licensing examination rescinds this exemption. (3-30-06)

IDAPA 27 - IDAHO STATE BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0701

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-1717, 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.

Sections 000 through 006 have been added as required major sections, pursuant to comments from the Office of the Administrative Rules Coordinator:

Text has been added and amended as an outgrowth of comments received and for the purposes of clarification.

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 September 5, 2007 Idaho Administrative Bulletin, Vol. 07-9, pages 217 through 218.

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 pending rule, contact Jan Atkinson, Senior Compliance Officer, (208) 334-2356.

DATED this 29th day of October, 2007.

Jan Atkinson, Senior Compliance Officer
Idaho Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720, Boise, ID 83720-0067
Phone: (208) 334-2356 / Facsimile: (208) 334-3536

THE FOLLOWING NOTICE 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 54-1717, 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 19, 2007.

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:

Pursuant to Section 54-1703, Idaho Code, it is a purpose of the Idaho Pharmacy Act "to promote, preserve and protect the health, safety and welfare of the public by and through the effective control and regulation of the practice of pharmacy . . .". In the furtherance of that purpose, it is appropriate to amend IDAPA 27.01.01.464 regarding the filling of prescriptions for controlled substances by licensed pharmacists to require that persons receiving controlled substances be positively identified by staff at the pharmacy at the time any controlled substance is dispensed directly to an individual at the pharmacy. The proposed rule provides for identification of persons receiving controlled substances at a pharmacy, describes the manner of satisfying the positive identification requirement, and provides exceptions to the identification requirements.

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 of the simple nature of the rule change and because pharmacists are in favor of this proposal.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jan Atkinson, Senior Compliance Officer, (208) 334-2356.

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 26, 2007.

DATED this 3rd day of August 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

000. LEGAL AUTHORITY.
This chapter is adopted in accordance with Section 54-1717, Idaho Code. *( )*

001. TITLE AND SCOPE.

01. Title*. These rules shall be cited in full as IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy."* *( )*

02. Scope*. These rules include, but are not limited to, the minimum standards for, and the control and regulation of, the practice of pharmacy in the state of Idaho and the registration of drug outlets.* *( )*

002. WRITTEN INTERPRETATIONS.
In accordance with Title 54, Chapter 17, Idaho Code, the Board may have 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. These documents, if any, are available for public inspection at the Board office. *( )*

003. ADMINISTRATIVE APPEALS.
The Idaho Rules of Administrative Procedure of the Attorney General on contested cases, IDAPA 04.11.01, "Idaho Rules of Administrative Procedure," Section 100, et. seq., shall apply in addition to Board of Pharmacy Rules, IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy." *( )*

004. INCORPORATION BY REFERENCE.
There are no documents that have been incorporated by reference into these rules. *( )*

005. OFFICE INFORMATION.

01. Street Address*. The office of the Board of Pharmacy is located at 3380 Americana Terrace, Suite 320, Boise, Idaho.* *( )*

02. Mailing Address*. The mailing address of the Board is P. O. Box 83720, Boise, Idaho 83720-0067.*
( )

03. Telephone Number*. The telephone number of the Board is (208) 334-2356.* *( )*

04. ***Facsimile Number****. The Board's fax number is (208) 334-3536.* *( )*

05. ***Electronic Address****. The Board's web address is http://bop.accessidaho.org/.* *( )*

006. PUBLIC RECORDS ACT COMPLIANCE.
Board of Pharmacy records are subject to, and in compliance with, the provisions of the Idaho Public Records Act, Title 9, Chapter 3, Idaho Code. *( )*

00~~0~~7. -- 009. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

464. FILLING ~~*OF A PRESCRIPTION FOR A*~~ CONTROLLED SUBSTANCE PRESCRIPTION AND POSITIVE IDENTIFICATION.

01. Filling and Dispensing. No person other than a registered pharmacist under the laws of this state shall be responsible for the filling and dispensing of a prescription for a controlled substance. ( )

02. Identification. Persons receiving controlled substances shall be positively identified by staff at the pharmacy at the time any controlled substance is dispensed directly to an individual at the pharmacy. ( )

a. Positive identification shall consist of either a valid, current state or military drivers license or identification card, or a valid, current passport, each of which must contain a photo of the individual and the individual's signature. For each controlled substance prescription dispensed directly to an individual at the pharmacy, the pharmacy shall: *( )*

i. Make and maintain a photocopy of the identification presented; or ( )

ii. Maintain a record of the name of the person receiving the prescribed controlled substance, *which record shall contain notation of the type of positive identification presented by such person; the state, military branch, or other government entity issuing the identification; and the specific identification number of the drivers license, identification card, or passport.* *( )*

b. In lieu of these means of positive identification, an individual whose identity is personally and positively known to a staff member of the pharmacy who is present and who identifies the individual at the time of delivery of the prescribed controlled substance may be so identified by the staff member~~.~~; in such instances, the pharmacy shall maintain a record of: ~~*(4-11-06)*~~( )

i. The name of the person receiving the prescribed controlled substance (if other than the patient); ( )

ii. A notation indicating that the patient or other person receiving the prescribed controlled substance was known to the pharmacy staff; and ( )

iii. The name of the pharmacy staff person making the identification. *( )*

c. *The provisions in Paragraphs 464.02.a. and 464.02.b. of these rules do not apply to a prescription dispensed directly to the patient at the pharmacy if:* *( )*

i. The prescription is to be paid for, in whole or in part, by an insurer; *( )*

ii. The pharmacy is part of the health care facility where the patient is being treated. ( )

03. Retrieval of Identification Records. The identification records required under Subsection 464.02 of these rules may be maintained by the pharmacy in any fashion provided that the pharmacy must be able to produce such records upon any lawful request, and match the prescription filled with the positive identification records for the person receiving the prescribed controlled substances, as required in Paragraphs 464.02.a. and 464.02.b. of these rules, within no more than two (2) business days from the date of the request. ( )

IDAPA 27 - IDAHO STATE BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0702

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-1717, 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 5, 2007 Idaho Administrative Bulletin, Vol. 07-9, pages 219 and 220.

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 Jan Atkinson, Senior Compliance Officer, (208) 334-2356.

DATED this 16th day of October, 2007.

Jan Atkinson
Senior Compliance Officer
Idaho Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Facsimile: (208) 334-3536

THE FOLLOWING NOTICE 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 54-1717, 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 19, 2007.

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:

IDAPA 27.01.01.177 provides for "limited service pharmacies" which are retail drug outlets that are not community pharmacies but limit the types of drug orders that may be filled. This rule further provides that, where appropriate, the rules applicable to institutional and retail pharmacies may be applied to limited service pharmacies. IDAPA 27.01.01.469.01 contains requirements for all community and mail service pharmacies regarding all Schedule II, III, and IV controlled substance prescriptions filled by the pharmacies. The proposed rule change would amend subsection 469.01 to add limited service pharmacies to those pharmacies required by the rule to report data regarding controlled substance prescriptions. Thus, limited service pharmacies permitted pursuant to IDAPA 27.01.01.177 to fill Schedule II, III, or IV controlled substance prescriptions would be required to report data regarding those prescriptions pursuant to IDAPA 27.01.01.469.01 as are community and mail service pharmacies. The rule changes add "limited service pharmacies" to IDAPA 27.01.01.469.01 so the list of pharmacies in that rule would read: "All community, limited service, and mail service pharmacies . . .".

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 of the simple nature of the rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jan

Atkinson, Senior Compliance Officer, (208) 334-2356.

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 26, 2007.

DATED this 3rd day of August 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

469. PRESCRIPTION REPORTING.

~~***01. Prescription Reporting Requirements***~~. All ~~*community and mail service*~~ pharmacies which hold a U.S. Drug Enforcement Administration (DEA) retail pharmacy registration will report by the first of every month or more often as directed by the Board, certain data, as required by the Board, on all schedule II, III and IV controlled substance prescriptions filled. The data may be reported in the form of diskette, direct computer link, magnetic tape or other method as approved by the Board. ~~*(7-1-98)*~~(____)

~~***02. Reporting Not Required****. Prescriptions for controlled substances filled for patients in long term care facilities, are not required to be reported.* *(7-1-98)*~~

IDAPA 27 - IDAHO STATE BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0703

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-1717, 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:

Text has been added and amended as an outgrowth of comments received and for the purposes of clarification.

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 Book 2 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 188 through 199.

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 pending rule, contact Jan Atkinson, Senior Compliance Officer, (208) 334-2356.

DATED this 29th day of October 2007.

Jan Atkinson
Senior Compliance Officer
Idaho Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720, Boise, ID 83720-0067
Phone: (208) 334-2356 / Facsimile: (208) 334-3536

IDAHO STATE BOARD OF PHARMACY ***Docket No. 27-0101-0703***
Rules of the Idaho State Board of Pharmacy ***PENDING RULE***

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is August 3, 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 rulemaking procedures have been initiated. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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 Idaho Legislature in 2007 enacted comprehensive legislation regarding the licensing of wholesale distributors and the providing of prescription drug pedigrees. 2007 Session Law, Chapter 319 (S.B. No. 1184), pp. 948 through 959. The legislation is known as the Wholesale Drug Distribution Act. The Act necessitates revision of the Board of Pharmacy's existing rules regarding wholesalers in order to implement the new legislation. The proposed rule implements the licensing requirements, bonding requirements, and drug pedigree requirements required by the Idaho Wholesale Drug Distribution Act, which Act is a comprehensive revision of the former wholesale drug distribution laws.

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

The proposed changes are needed to comply with amendments in governing law regarding the licensing of wholesale distributors and the providing of prescription drug pedigrees.

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

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

NEGOTIATED RULEMAKING: Negotiated rulemaking was not utilized in view of the need

for a temporary rule. This temporary rule is necessary in order to comply with amendments in governing law enacted by the 2007 Idaho Legislature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Jan Atkinson, Senior Compliance Officer, (208) 334-2356.

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 24, 2007.

DATED this 15th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

321. DEFINITIONS.

01. **Authentication**. To affirmatively verify before any wholesale distribution of a prescription drug occurs that each transaction listed on the pedigree has occurred. ( )

02. ~~***Use***. *Articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animal.*~~ **Authorized Distributor of Record**. A wholesale distributor with whom a manufacturer has established an ongoing relationship to distribute the manufacturer's prescription drug. An ongoing relationship is deemed to exist between such wholesale distributor and a manufacturer when the wholesale distributor, including any affiliated group of the wholesale distributor, as defined in section 1504 of the Internal Revenue Code, complies with the following: ~~*(7-1-93)*~~( )

a. The wholesale distributor has a written agreement currently in effect with the manufacturer evidencing such ongoing relationship; and ( )

b. The wholesale distributor is listed on the manufacturer's current list of authorized distributors of record, which is updated by the manufacturer on no less than a monthly basis. ( )

03. ~~***Other***. *Articles other than food intended to affect the structure or any function of the body of man or other animals.*~~ **Chain Pharmacy Warehouse**. A physical location for prescription drugs that acts as a central warehouse and performs intra-company sales or transfers of such drugs to a group of chain pharmacies that have the same common ownership and control. ~~*(7-1-93)*~~( )

04. **Co-Licensed Partner or Product**. An instance where two (2) or more parties have the right to engage in the manufacturing and/or marketing of a prescription drug, consistent

with the federal Food and Drug Administration's implementation of the Prescription Drug Marketing Act. ( )

0~~4~~5. Components. Articles intended for use as a component of any articles specified in Subsection 321.01, 321.02, or 321.03 of these rules. ~~(7-1-93)~~( )

06. Drop Shipment. The sale of a prescription drug to a wholesale distributor or chain pharmacy warehouse by the manufacturer of the prescription drug, or that manufacturer's co-licensed product partner, that manufacturer's third party logistics provider, or that manufacturer's exclusive distributor, whereby the wholesale distributor or chain pharmacy warehouse takes title but not physical possession of such prescription drug and the wholesale distributor invoices the pharmacy or chain pharmacy warehouse, or other person authorized by law to dispense or administer such drug to a patient, and the pharmacy or chain pharmacy warehouse or other authorized person receives delivery of the prescription drug directly from the manufacturer, or that manufacturer's third party logistics provider, or that manufacturer's exclusive distributor. ( )

0~~1~~7. Drug. Articles recognized as drugs in the official United States Pharmacopoeia, official National Formulary, official Homeopathic Pharmacopoeia, other drug compendia or any supplement to any of them. (7-1-93)

08. Facility. Facility of a wholesale distributor where prescription drugs are stored, handled, repackaged, or offered for sale. ( )

0~~6~~9. Manufacturer. ~~*Manufacturer means anyone who is*~~ A person licensed or approved by the federal Food and Drug Administration to engage~~*d*~~ in ~~*manufacturing, preparing, propagating, compounding, processing, packaging, repackaging or labeling of a drug*~~ the manufacture of drugs or devices, consistent with the federal Food and Drug Administration definition of "manufacturer" under its regulations and guidance implementing the Prescription Drug Marketing Act. ~~(7-1-93)~~( )

10. Manufacturer's Exclusive Distributor. Anyone who contracts with a manufacturer to provide or coordinate warehousing, distribution, or other services on behalf of a manufacturer and who takes title to that manufacturer's prescription drug, but who does not have general responsibility to direct the sale or disposition of the manufacturer's prescription drug. Such manufacturer's exclusive distributor must be licensed as a wholesale distributor under Section 54-1753, Idaho Code, and, to be considered part of the normal distribution channel, must also be an authorized distributor of record. ( )

11. Normal Distribution Channel. A chain of custody for a prescription drug that goes from a manufacturer of the prescription drug, from that manufacturer to that manufacturer's co-licensed partner, from that manufacturer to that manufacturer's third party logistics provider, or from that manufacturer to that manufacturer's exclusive distributor, either directly or by drop shipment to: ( )

a. A pharmacy to a patient; ( )

b. Other designated persons authorized by law to dispense or administer such drug to

a patient; ( )

c. A wholesale distributor to a pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug to a patient; ( )

d. A wholesale distributor to a chain pharmacy warehouse to that chain pharmacy warehouse's intra-company pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug to a patient; or ( )

e. A chain pharmacy warehouse to the chain pharmacy warehouse's intra-company pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug to a patient. ( )

12. **Pedigree**. A document or electronic file containing information that records each wholesale distribution of any given prescription drug. ( )

***07*13. Prescription Drug**. *Prescription drug means a*Any *human* drug, including any biological product, except for blood and blood components intended for transfusion or biological products that are also medical devices, required by *F*federal *or Idaho* law or *rule* federal regulation to be dispensed only by a prescription, including finished dosage forms and *active ingredients* bulk substances, subject to Section 503(b) of the *F*federal Food, Drug and Cosmetic Act. *(7-1-93)*( )

14. **Repackage**. Repackaging or otherwise changing the container, wrapper, or labeling to further the distribution of a prescription drug, excluding that completed by the pharmacist responsible for dispensing product to the patient. ( )

15. **Repackager**. A person who repackages. ( )

***05*16. Sample**. *Drug sample means a*A unit of a drug that is not intended to be sold and is intended to promote the sale of the drug. *(7-1-93)*( )

17. **Third Party Logistics Provider**. Anyone who contracts with a prescription drug manufacturer to provide or coordinate warehousing, distribution, or other services on behalf of a manufacturer, but does not take title to the prescription drug or have general responsibility to direct the prescription drug's sale or disposition. Such third party logistics provider must be licensed as a wholesale distributor under Section 54-1753, Idaho Code, and, to be considered part of the normal distribution channel, must also be an authorized distributor of record. ( )

***0*18. Wholesale Distribution**. Distribution of prescription drugs to persons other than a consumer or patient, but does not include: *(7-1-93)*( )

a. *The sale, purchase or trade of a drug or an offer to sell, purchase or trade a drug for emergency medical reasons; for purposes of this section "emergency medical reasons" includes transfers of prescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage, except that the gross dollar value of such transfers shall not exceed five percent (5%) of the total prescription drug sales revenue of either the transferor or transferee pharmacy during any twelve (12) consecutive month period.* Intracompany sales of

prescription drugs, meaning any transaction or transfer between any division, subsidiary, parent or affiliated or related company under common ownership and control of a corporate entity, or any transaction or transfer between co-licensees of a co-licensed product. ~~(7-1-93)~~(____)

b. The sale, purchase, ~~or~~ distribution, trade, or transfer of a prescription drug~~, an~~ or offer to sell, purchase, ~~or~~ distribute, trade, or transfer a prescription drug~~, or the dispensing of a drug pursuant to a prescription~~ for emergency medical reasons. ~~(7-1-93)~~(____)

c. The ~~lawful~~ distribution of prescription drug samples by manufacturers' representatives~~ or distributor's representatives~~. ~~(7-1-93)~~(____)

d. ~~The sale, purchase or trade of blood and blood components intended for transfusion.~~ Drug returns, when conducted by a hospital, health care entity, or charitable institution in accordance with 21 CFR 203.23. ~~(7-1-93)~~(____)

e. ~~Intracompany transfers among hospitals or health care entities under common control, transfers among members of a group purchasing organization and transfers between a charitable organization and a nonprofit affiliate.~~ The sale of minimal quantities of prescription drugs by retail pharmacies to licensed practitioners for office use. ~~(7-1-93)~~(____)

f. The sale, purchase, or trade of a drug, an offer to sell, purchase, or trade a drug, or the dispensing of a drug pursuant to a prescription. (____)

g. The sale, transfer, merger, or consolidation of all or part of the business of a pharmacy or pharmacies from or with another pharmacy or pharmacies, whether accomplished as a purchase and sale of stick or business assets. (____)

h. The sale, purchase, distribution, trade, or transfer of a prescription drug from one (1) authorized distributor of record to one (1) additional authorized distributor of record when the manufacturer has stated in writing to the receiving authorized distributor of record that the manufacturer is unable to supply such prescription drug and the supplying authorized distributor of record states in writing that the prescription drug being supplied had, until that time, been exclusively in the normal distribution channel. (____)

i. The delivery of, or offer to deliver, a prescription drug by a common carrier solely in the common carrier's usual course of business of transporting prescription drugs, and such common carrier does not store, warehouse, or take legal ownership of the prescription drug. (____)

j. The sale or transfer from a retail pharmacy or chain pharmacy warehouse of expired, damaged, returned, or recalled prescription drugs to the original manufacturer or third party returns processor, including a reverse distributor. (____)

~~0~~19. Wholesale Distributor. ~~Wholesale distributor means a~~Anyone engaged in wholesale distribution of drugs, including, but not limited to: manufacturers; repackagers; own-label distributors; private-label distributors; jobbers; brokers; warehouses, including manufacturer's and distributor's warehouses~~,~~; manufacturer's exclusive distributors; authorized distributors of record; drug wholesalers or distributors; independent wholesale drug traders;

specialty wholesale distributors; third party logistics providers; retail pharmacies that conduct wholesale distribution; and chain ~~drug~~ pharmacy warehouses ~~and wholesale drug warehouses; independent wholesale drug traders; retail pharmacies; and drug outlets~~ that conduct wholesale distributions. To be considered part of the normal distribution channel, such wholesale distributor, except for a chain pharmacy warehouse not engaged in wholesale distribution, must also be an authorized distributor of record. ~~(7-1-93)~~( )

322. WHOLESALE DRUG DISTRIBUTOR LICENSING REQUIREMENT.

01. License Required. Every wholesale distributor~~, wherever located,~~ who engages in wholesale distribution ~~into, out~~ of~~, or within this state~~ prescription drugs must be licensed by the Idaho Board of Pharmacy in accordance with the laws and rules of this state before engaging in wholesale distribution of prescription drugs, and every nonresident wholesale distributor, if it ships prescription drugs into this state, must be licensed by the Idaho Board of Pharmacy in accordance with the laws and rules of this state before engaging in wholesale distribution of prescription drugs. ~~(7-1-93)~~( )

02. ~~Reciprocity. Those wholesale drug distributors not located within the state may obtain the license required by this rule on the basis of reciprocity if the out-of-state distributor possesses a valid license granted by another state pursuant to standards comparable to those in Idaho and the other state extends reciprocal treatment to distributors of this state.~~ **Exemption**. Manufacturers distributing their own federal Food and Drug Administration approved drugs and devices are exempt from the wholesale distributor licensing requirement unless federal law or regulation requires such manufacturers to be licensed in this state as wholesale distributors. ~~(7-1-93)~~( )

323. MINIMUM ~~REQUIRED INFORMATION~~ REQUIREMENTS FOR LICENSURE.

01. ~~Requirements~~ Information Under Oath. The Idaho Board of Pharmacy requires the following information under oath from each wholesale drug distributor as part of the initial licensing procedure and as part of any renewal of such license: ~~(7-1-93)~~( )

a. The name, full business address, and telephone number of the licensee. (7-1-93)

b. All trade or business names used by the licensee. (7-1-93)

c. Addresses, telephone numbers, and the names of contact persons for the facility used by the licensee for the storage, handling, and distribution of prescription drugs. ~~(7-1-93)~~( )

d. The type of ownership or operation (i.e., partnership, corporation, or sole proprietorship). (7-1-93)

e. The name(s) of the owner and/or operator of the licensee, including: (7-1-93)

i. If a person, the name of the person. (7-1-93)

ii. If a partnership, the name of each partner, and the name of the partnership.

(7-1-93)

iii. If a corporation, the name and title of each corporate officer and director, the corporate names, and the name of the state of incorporation, and the name of the parent company, if any. (7-1-93)

iv. If a sole proprietorship, the full name of the sole proprietor and the name of the business entity. (7-1-93)

f. A list of all licenses and permits issued to the applicant/licensee by any other state that authorizes the applicant/licensee to purchase or possess prescription drugs. (____)

g. Any convictions of the applicant/licensee under any federal, state, or local laws relating to wholesale or retail prescription drug distribution or distribution of controlled substances. (____)

h. Any felony convictions of the applicant/licensee under federal, state, or local law. (____)

i. Any discipline of the applicant/licensee by a regulatory agency in any state for violating any federal, state, or local laws relating to wholesale or retail prescription drug distribution or distribution of controlled substances. (____)

j. The name of the licensee's designated representative for the facility, together with the personal information statement and fingerprints required for such individual pursuant to Paragraph 323.01.k. of these rules. (____)

k. For each individual identified by the licensee as a designated representative pursuant to Paragraph 323.01.g of these rules, the licensee shall provide the following information: (____)

i. The individual's places of residence for the past seven (7) years. (____)

ii. The individual's date and place of birth. (____)

iii. The individual's occupations, positions of employment, and offices held during the past seven (7) years. (____)

iv. The principal business and address of any business, corporation, or other organization in which each such office of the individual was held or in which each such occupation or position of employments was carried on. (____)

v. Whether the individual during the past seven (7) years has been the subject of any proceeding for the revocation of any license or any criminal violation and, if so, the nature of the proceeding and the disposition of the proceeding. (____)

vi. Whether the individual during the past seven (7) years has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from either violating any federal

or state law or regulation the possession, control, or distribution of prescription drugs or criminal violations, together with details concerning any such event. ( )

vii. A description of any involvement by the individual during the past seven (7) years with any business, including any investments, other than the ownership of stock in a publicly traded company or mutual fund, which manufactured, administered, prescribed, distributed, or stored pharmaceutical products, and any lawsuits in which such businesses were named as a party. ( )

viii. A description of any felony criminal offense of which the individual, as an adult, was found guilty, regardless of whether adjudication of guilt was withheld or whether the individual pled guilty or nolo contendere. If the individual has a criminal conviction under appeal and a copy of the notice of appeal of that criminal offense is submitted to the Board, the licensee must submit to the Board within fifteen (15) days after disposition of the appeal a copy of the final written order of disposition. ( )

ix. A photograph of the individual taken in the previous year. ( )

02. License Required for Each ~~*Location*~~ Facility. ~~*Where operations are conducted at more than one (1) location by*~~ If a ~~*single*~~ wholesale distributor~~,~~ distributes prescription drugs from more than one (1) facility, the wholesale distributor shall obtain a license for each ~~*such location shall be licensed by the Idaho Board of Pharmacy*~~ facility. ~~*(7-1-93)*~~( )

03. Changes in Information Must Be Submitted to Board. Changes in, or corrections to, any information ~~*in this Section*~~ provided pursuant to Subsection 323.01 of these rules shall be submitted to the Idaho Board of Pharmacy under oath at the time of license renewal. ~~*(7-1-93)*~~( )

04. Requirement for Bond or Equivalent Security. Every wholesale distributor required to be licensed in this state shall submit to the Idaho Board of Pharmacy a bond of not less than one hundred thousand dollars ($100,000), or other equivalent means of security acceptable to the Board and payable to the Board, such as an irrevocable letter of credit issued by a third party acceptable to the Board or a deposit in a trust account or financial institution acceptable to the Board. *Chain pharmacy warehouses that are not engaged in wholesale distribution are exempt from the bond requirement.* Such bond or equivalent security shall secure payment of any administrative fines or penalties imposed by the Board and any fees or costs incurred by the Board regarding that licensee when those fines, penalties, fees, or costs are authorized under the laws of this state and the licensee fails to pay thirty (30) days after the fines, penalties, fees, or costs become final. The Board may make a claim against such bond or equivalent security until one (1) year after the licensee's license cease to be valid. A single bond may suffice to cover all facilities operated by the licensee in this state. *( )*

05. Separate Fund for Deposit of Bonds. The Board shall deposit the bonds required pursuant to Subsection 323.04 of these rules in a fund established by the Board separate from its other accounts. ( )

06. Accreditation by VAWD. The Idaho Board of Pharmacy will recognize inspection and accreditation of wholesale distributors by the National Association of Board of Pharmacy's

Verified-Accredited Wholesale Distributors (VAWD) program. ( )

07. **License by Reciprocity**. The Idaho Board of Pharmacy may license by reciprocity a wholesale distributor that is licensed under the laws of another state if*:* *( )*

a. *T*he *wholesale distributor* is accredited by the National Association of Board of Pharmacy's Verified-Accredited Wholesale Distributor's (VAWD) program*; or* *( )*

b. *The wholesale distributor is licensed under the laws of another state pursuant to standards comparable to those in Idaho and acceptable to the Board and the other state extends reciprocal treatment to distributors of this state.* *( )*

324. MINIMUM QUALIFICATIONS.

01. **Mandatory Denial of Licensure for Wholesale Distribution of Drugs**. The Idaho Board of Pharmacy shall not issue a wholesale distributor license to an applicant if the designated representative does not meet all of the following qualifications: ( )

a. Is at least twenty-one (21) years of age. ( )

b. Has been employed full-time for at least three (3) years in a pharmacy or with a wholesale distributor in a capacity related to the dispensing and distribution of, and recordkeeping related to, prescription drugs. ( )

c. Is employed by the applicant full-time in a managerial level position. ( )

d. Is actively involved in and aware of the actual daily operation of the wholesale distributor. ( )

e. Is physically present at the facility of the applicant during regular business hours, except when the absence of the designated representative is authorized including, but not limited to, sick leave and vacation leave. ( )

f. Is serving in the capacity of a designated representative for only one (1) applicant at a time, except where more than one (1) licensed wholesale distributor is co-located in the same facility and such wholesale distributors are members of an affiliated group, as defined in Section 1504 of the Internal Revenue Code. ( )

g. Does not have any convictions under any federal, state, or local law relating to wholesale or retail prescription drug distribution or distribution of controlled substances. ( )

h. Does not have any felony convictions under federal, state, or local law. ( )

0~~1~~2. **Other Eligibility** ***~~for Licensure for Wholesale Distribution of Drugs~~*** **Factors**. Besides the qualifications of the applicant's designated representative, ~~T~~the Idaho Board of Pharmacy will consider the following factors in determining the applicant's eligibility for licensure ~~*of persons who engage in the*~~ as a wholesale ~~*distribution of drugs*~~ distributor.
~~*(7-1-93)*~~( )

a. Any convictions of the applicant under any federal, state, or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances. (7-1-93)

b. Any felony convictions of the applicant under federal, state, or local laws. (7-1-93)

c. The applicant's past experience in the manufacture or distribution of drugs, including controlled substances. (7-1-93)

d. The furnishing by the applicant of false or fraudulent material in any application made in connection with drug manufacturing or distribution. (7-1-93)

e. Suspension or revocation by federal, state, or local government of any license currently or previously held by the applicant for the manufacture or distribution of any drugs, including controlled substances. (7-1-93)

f. Compliance with licensing requirements under previously granted licenses, if any. (7-1-93)

g. Compliance with the requirements to maintain and/or make available to the state licensing authority or to federal, state, or local law enforcement officials those records required to be maintained by wholesale drug distributors. ~~*(7-1-93)*~~(____)

h. Any other factors or qualifications the Idaho Board of Pharmacy considers relevant to and consistent with the public health and safety. (7-1-93)

0~~2~~3. Denial of License to Applicant. The Idaho Board of Pharmacy reserves the right to deny a license to an applicant if it determines that the granting of such a license would not be in the ~~*public*~~ interest ~~*based on*~~ of the public health, safety, and welfare ~~*considerations*~~. ~~*(7-1-93)*~~(____)

325. PERSONNEL.

01. Employment of Adequate Personnel. The licensed wholesale distributor shall employ adequate personnel with the education and experience necessary to safely and lawfully engage in the wholesale distribution of drugs. ~~*(7-1-93)*~~(____)

02. Continuing Training for Designated Representative. A licensed wholesale distributor's designated representative must receive and complete: (____)

a. Continuing *training* specified by the Idaho Board of Pharmacy regarding federal and state laws regarding wholesale distribution of prescription drugs. *(____)*

b. If no formal continuing *training* is specified by the Idaho Board of Pharmacy, training programs that address applicable federal and state laws regarding wholesale distribution of prescription drugs and are provided by qualified in-house specialists, outside counsel, or consulting specialists with capabilities to help ensure compliance. *(____)*

326. MINIMUM REQUIREMENTS.

01. Requirements for Storage and Handling of Drugs. The following are required for the storage and handling of drugs, and for the establishment and maintenance of drug distribution records by wholesale drug distributors and their officers, designated representative, agents, ~~*representatives,*~~ and employees. ~~*(7-1-93)*~~( )

02. Drug Facility Requirements. All facilities at which drugs are stored, warehoused, handled, held, offered, marketed, or displayed shall: (7-1-93)

a. Be of suitable size and construction to facilitate cleaning, maintenance, and proper operations; (7-1-93)

b. Have storage areas designed to provide adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions; (7-1-93)

c. Have a quarantine area for storage of prescription drugs that are outdated, damaged, deteriorated, misbranded, or adulterated, or that are in medicate or sealed secondary containers that have been opened. (7-1-93)

d. Be maintained in a clean and orderly condition. (7-1-93)

e. Be free from infestation by insects, rodents, birds, or vermin of any kind. (7-1-93)

03. Security of Wholesale Drug Distribution Facilities. All facilities used for wholesale drug distribution shall be secure from unauthorized entry. (7-1-93)

a. Access from outside the premises shall be kept to a minimum and be well controlled. (7-1-93)

b. The outside perimeter of the premises shall be well lighted. (7-1-93)

c. Entry into areas where drugs are held shall be limited to authorized personnel. (7-1-93)

d. All facilities shall be equipped with an alarm system to detect entry after hours. (7-1-93)

e. All facilities shall be equipped with a security system that will provide suitable protection against theft and diversion. (7-1-93)

f. When appropriate, the security system shall provide protection against theft or diversion that is facilitated or hidden by tampering with computers or electronic records. (7-1-93)

04. Proper Storage of Drugs. All drugs shall be stored at appropriate temperatures and under appropriate conditions in accordance with requirements, if any, in the labeling of such drugs, or with requirements in the current edition of an official compendium. (7-1-93)

a. If no storage requirements are established for a drug, the drug may be held at "controlled" room temperature, as defined in an official compendium, to help ensure that its identity, strength, quality, and purity are not adversely affected. (7-1-93)

b. Appropriate manual, electromechanical, or electronic temperature and humidity recording equipment, devices, and/or logs shall be utilized to document proper storage of drugs. (7-1-93)

c. The record keeping requirements in Subsection 326.07 shall be followed for all stored drugs. (7-1-93)

05. Examination of Materials. Upon receipt, each outside shipping container shall be visually examined for identity and to prevent the acceptance of contaminated drugs or drugs that are otherwise unfit for distribution. (7-1-93)

a. This examination shall be adequate to reveal container damage that would suggest possible contamination or other damage to the contents. (7-1-93)

b. Each outgoing shipment shall be carefully inspected for identity of the drug products and to ensure that there is no delivery of drugs that have been damaged in storage or held under improper conditions. (7-1-93)

c. The record keeping requirements in Subsection 326.07 of this section shall be followed for all incoming and outgoing drugs. (7-1-93)

06. Returned, Damaged, and Outdated Drugs. Drugs that are outdated, damaged, deteriorated, misbranded, or adulterated shall be quarantined and physically separated from other drugs until they are destroyed or returned to ~~*their supplier*~~ the original manufacturer or third party returns processor *including a reverse distributor*. ~~*(7-1-93)*~~*( )*

a. Any drugs whose immediate or sealed outer or sealed secondary containers have been opened or used shall be identified as such, and shall be quarantined and physically separated from other drugs until they are either destroyed or returned to the ~~*supplier*~~ original manufacturer or third party returns processor *including a reverse distributor*. ~~*(7-1-93)*~~*( )*

b. If the conditions under which a drug has been returned cast doubt on the drug's safety, identity, strength, quality, or purity, then the drug shall be destroyed, or returned to the supplier, unless examination, testing, or other investigation proves that the drug meets appropriate standards of safety, identity, strength, quality, and purity. (7-1-93)

c. In determining whether the conditions under which a drug has been returned cast doubt on the drug's safety, identity, strength, quality, or purity, the wholesale drug distributor shall consider, among other things, the conditions under which the drug has been held, stored, or shipped before or during its return and the condition of the drug and its container, carton, or labeling, as a result of storage or shipping. (7-1-93)

d. The record keeping requirements in Subsection 326.07 shall be followed for all

outdated, damaged, deteriorated, misbranded, or adulterated drugs. (7-1-93)

07. Record Keeping by Wholesale Drug Distributors. Wholesale drug distributors shall establish and maintain inventories and records of all transactions regarding the receipt and distribution or other disposition of drugs. (7-1-93)

a. The records shall include: (7-1-93)

i. The source of the drugs, including the name and principal address of the seller or transferor, and the address of the location from which the drugs were shipped. (7-1-93)

ii. The identity and quantity of the drugs received and distributed or disposed of. (7-1-93)

iii. The dates of receipt and distribution or other disposition of the drugs. (7-1-93)

b. Inventories and records shall be made available for inspection and photocopying by any authorized official of any governmental agency charged with enforcement of these rules for a period of two (2) years following disposition of the drugs. (7-1-93)

c. Records described in this section that are kept at the inspection site or that can be immediately retrieved by computer or other electronic means shall be readily available for authorized inspection during the retention period. (7-1-93)

d. Records kept at a central location apart from the inspection site and not electronically retrievable shall be made available for inspection within two (2) working days of a request by an authorized official of any governmental agency charged with enforcement of these rules. (7-1-93)

327. WRITTEN POLICIES AND PROCEDURES.
Wholesale drug distributors shall establish, maintain, and adhere to written policies and procedures, which shall be followed for the receipt, security, storage, inventory, and distribution of drugs, including policies and procedures for identifying, recording, and reporting losses or thefts, and for correcting all errors and inaccuracies in inventories. (7-1-93)

01. Distribution of Oldest Approved Stock First. A procedure whereby the oldest approved stock of a drug product is distributed first but may permit deviation from this requirement if such deviation is temporary and appropriate. (7-1-93)

02. Procedure for Recalls and Withdrawals. A procedure to be followed for handling recalls and withdrawals of drugs that is adequate to deal with recalls and withdrawals due to: (7-1-93)

a. Any action initiated at the request of the Food and Drug Administration or other federal, state, or local law enforcement or other government agency, including the Idaho Board of Pharmacy. (7-1-93)

b. Any voluntary action by the manufacturer to remove defective or potentially

defective drugs from the market. (7-1-93)

c. Any action undertaken to promote public health and safety by the replacing of existing merchandise with an improved product or new package design. (7-1-93)

03. Procedure for Crisis Situations. A procedure to ensure that wholesale drug distributors prepare for, protect against, and handle any crisis that affects security or operation of any facility in the event of strike, fire, flood, or other natural disaster, or other situations of local, state, or national emergency. (7-1-93)

04. Segregation and Disposal of Outdated Drugs. A procedure to ensure that any outdated drugs shall be segregated from other drugs and either returned to the original manufacturer or third party returns processor *including a reverse distributor* or destroyed which shall provide for written documentation of the disposition of outdated drugs and maintained for two (2) years after disposition of the outdated drugs. ~~*(7-1-93)*~~*( )*

328. RESPONSIBLE PERSONS.
Wholesale drug distributors shall establish and maintain lists of officers, directors, managers, the designated representative, and other persons in charge of wholesale drug distribution, storage, and handling, including a description of their duties and a summary of their qualifications.
~~*(7-1-93)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

331. PEDIGREE.

01. Pedigree Contents. A pedigree for each prescription drug shall contain the following information: ( )

a. The proprietary and established name of the prescription drug. ( )

b. The container size of the prescription drug. ( )

c. The number of containers. ( )

d. The dosage form. ( )

e. The dosage strength. ( )

f. The lot number with expiration dates and the national drug code number of the prescription drug. ( )

g. The name of the manufacturer and repackager, if applicable, of the finished prescription drug product. ( )

h. The name, address, telephone number, and, if available, the e-mail address, of each owner of the prescription drug and each wholesale distributor of the prescription drug. ( )

i. The name and address of each location from which the prescription drug was shipped, if different from the owner's. ( )

j. The dates of each transaction. ( )

k. A certification that each recipient has authenticated the pedigree. *( )*

l. The name and address of each recipient of the prescription drug. ( )

02. **Pedigree Format**. The pedigree format shall include the contents described in Subsection 331.01 of these rules and may be subject to the approval of the Idaho Board of Pharmacy. ( )

03. **Requirement of a Pedigree**. Each person who is engaged in wholesale distribution of prescription drugs, including repackagers but excluding the original manufacturer of the finished form of the prescription drug, that leaves or has ever left the normal distribution channel shall, before each wholesale distribution of such drug, provide a pedigree to the person who receives such drug. A retail pharmacy or chain pharmacy warehouse shall comply with the pedigree requirement only if the retail pharmacy or chain pharmacy warehouse engages in wholesale distribution. ( )

04. **Authentication**. Each person who is engaged in the wholesale distribution of a prescription drug, including repackagers but excluding the original manufacturer of the finished form of the prescription drug, who is provided a pedigree for a prescription drug and attempts to further distribute that prescription drug, shall affirmatively verify before any wholesale distribution of a prescription drug occurs that each transaction listed on the pedigree has occurred. ( )

05. **Maintenance of Pedigree**. The purchaser and the wholesale distributor of a prescription drug shall maintain the pedigree for not less than three (3) years from the date of sale or transfer. ( )

06. **Availability of Records for Inspection**. Pedigrees shall be made available to the Idaho Board of Pharmacy for inspection within five (5) business days of a request from the Board. ( )

33~~1~~2. FAILURE TO COMPLY.
A wholesale distributor's violation of, or ~~F~~failure to comply with, these rules may result in ~~*reprimand, suspension or revocation of license or other disciplinary action*~~ imposition by the Idaho Board of Pharmacy of any one (1) or more of the penalties provided in Section 54-1728, Idaho Code. ~~*(7-1-93)*~~( )

33~~2~~3. -- 350. (RESERVED).

IDAPA 27 - IDAHO STATE BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0704

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 54-1717, 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 5, 2007 Idaho Administrative Bulletin, Vol. 07-9, pages 221 through 224.

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 pending rule, contact Jan Atkinson, Senior Compliance Officer, (208) 334-2356.

DATED this 16th day of October, 2007.

Jan Atkinson, Senior Compliance Officer
Idaho Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720, Boise, ID 83720-0067
Phone: (208) 334-2356 / Facsimile: (208) 334-3536

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

IDAHO STATE BOARD OF PHARMACY ***Docket No. 27-0101-0704***
Rules of the Idaho State Board of Pharmacy ***PENDING 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 54-1717, 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 19, 2007.

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:

Section 54-1703, Idaho Code, states that one of the purposes of the Idaho Pharmacy Act is "to promote, preserve and protect the health, safety and welfare of the public by and through the effective control and regulation of the practice of pharmacy . . .". In pursuit of that purpose, the proposed new rule would create a "tech-check-tech" pilot project applicable to "hospitals" as defined in Section 39-1301(a), Idaho Code, that also qualify as an "institutional facility" with an "institutional pharmacy" as the later two terms are defined in IDAPA 27.01.01.252.01. The purpose of the pilot project is to allow designated pharmacy technicians within a hospital's institutional pharmacy to review the work of other pharmacy technicians in connection with the filling of floor and ward stock and unit dose distribution systems for hospital patients whose orders have previously been reviewed and approved by a licensed pharmacist. It is contemplated that if any alteration or combining of dosages is necessary, then a licensed pharmacist would be required to check the resulting dosage. The objective to be served by the pilot program is to free licensed pharmacists within an institutional pharmacy from routine tasks related to the checking of manufacturer or robotically prepared unit dose medications, which checking is capable of being performed by a trained technician, so that the pharmacist has additional time for other tasks within the practice of pharmacy as defined in Section 54-1704, Idaho Code, including, but not limited to, "participation in drug and device selection . . . [and] drug regimen reviews" with a view toward enhancing patient health care. The proposed rule contemplates that the Board of Pharmacy, through its Executive Director, may authorize specific hospitals with institutional pharmacies to participate in the pilot project, and that authorization to participate in the pilot project phase of the program would be at the discretion of the Board and the Executive Director. The Board of Pharmacy previously has undertaken other pilot projects, such as the telepharmacy pilot project under IDAPA 27.01.01.261-264.

The new rule authorizes a "tech-check-tech" pilot program within the institutional pharmacies of hospitals; defines the hospitals eligible to participate in the pilot program; provides that participation in the program during the pilot phase shall be at the discretion of the Board of Pharmacy and is Executive Director; restricts the scope of tasks that may be performed by a pharmacy technician designated to review the work of other pharmacy technicians; requires that hospitals participating in the program file with the Board of Pharmacy a writing program describing the duties, training, and monitoring for the

designated technicians; establishes the minimum requirements for the hospital's program; and requires that the director of the institutional pharmacy be responsible for all activities of pharmacy technicians in the "tech-check-tech" program to ensure that all activities are performed completely, safely, and without risk of harm to patients.

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 these rules implement a Board approved pilot project that is voluntary in nature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jan Atkinson, Senior Compliance Officer, (208) 334-2356.

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 26, 2007.

DATED this 3rd day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

270. TECHNICIAN-CHECKING-TECHNICIAN PILOT PROGRAM.

01. Nature of Pilot Program. The Board, through its executive director, may authorize institutional pharmacies located within acute care hospitals to participate in a Technician-Checking-Technician Pilot Program. The purpose of the Technician-Checking-Technician Pilot Program is to allow pharmacy technicians to review the work of other pharmacy technicians in connection with the filling of floor and ward stock and unit dose distribution systems for hospital patients whose orders have previously been reviewed and approved by a licensed pharmacist. During the pilot project phase of the Technician-Checking-Technician Pilot Program, designation to participate in the program shall be at the discretion of the Board and the executive director. ( )

02. Qualifying Institutional Pharmacies. Only an institutional pharmacy located within an acute care hospital, which for purposes of these rules is defined as a facility which is primarily engaged in providing, by or under the supervision of physicians, concentrated medical and nursing care on a twenty-four (24) hour basis to inpatients experiencing acute illness, shall be

eligible to receive authorization to conduct a pilot technician-checking-technician program.( )

03. **Written Program Filing**. Each institutional pharmacy authorized to conduct a pilot technician-checking-technician program shall have on file with the Board prior to initiating its technician-checking-technician program a written description of its program, which description shall contain, at a minimum: ( )

a. The name of the institutional pharmacy's pharmacist-in-charge. ( )

b. The name of the pharmacist, if different from the pharmacist-in-charge, assigned by the institutional pharmacy as the coordinator of its technician-checking-technician program. ( )

c. A description of the duties of the pharmacist assigned by the institutional pharmacy as coordinator of the technician-checking-technician program. ( )

d. A description of the duties of the pharmacy technician designated by the institutional pharmacy to perform the function of checking the work of other technicians. ( )

e. Identification of the types of medications with respect to which the designated pharmacy technician will perform the function of checking the work of other technicians. ( )

f. A description of the specialized and advanced training that shall be provided by the institutional pharmacy to each pharmacy technician designated by it to perform the function of checking the work of other technicians. ( )

g. A description of the monitoring and evaluation process that the institutional pharmacy shall utilize to ensure the on-going competency of each pharmacy technician designated by it to perform the function of checking the work of other technicians. ( )

h. A description of the means of identification the institutional pharmacy shall use to identify within the pharmacy those pharmacy technicians designated by it to perform the function of checking the work of other technicians. ( )

04. **Program Requirements**. Each institutional pharmacy authorized to conduct a pilot technician-checking-technician program shall comply with the following requirements: ( )

a. No pharmacy technician shall be designated by an institutional pharmacy to perform, nor shall such technician perform, the function of checking the work of other technicians without having received and competently completed the specialized and advanced training prescribed in the institutional pharmacy's written program description filed with the Board.( )

b. A pharmacy technician designated by an institutional pharmacy to perform the function of checking the work of other technicians may check the work of other technicians concerning the filling of floor and ward stock and unit dose distribution systems regarding manufacturer prepared or robotically prepared unit dose medications for hospital patients whose prescription orders have previously been reviewed and approved by a licensed pharmacist. The

checking function performed by the designated pharmacy technician shall be limited to those types of medications identified in the institutional pharmacy's written program description filed with the Board. If either the alteration of a unit dose or the combination of unit doses is required, then a licensed pharmacist shall verify the resulting unit dose alteration or combination of unit doses. ( )

c. The institutional pharmacy shall conduct ongoing monitoring and evaluation of each pharmacy technician designated by it to perform the function of checking the work of other technicians in order to ensure the ongoing competency of each such designated technician and the safety of patients. ( )

d. Each institutional pharmacy authorized to conduct a technician-checking-technician program shall maintain on its premises records available for inspection by the Board containing for each pharmacy technician designated by the institutional pharmacy to perform the function of checking the work of other technicians the date the pharmacy technician was so designated; the date the technician completed the specialized and advancing training prescribed in the written program description on file with the Board; the dates and results of all competency evaluations; and the dates of and reasons for any suspension or revocation by the institutional pharmacy or hospital of the pharmacy technician's designation to perform the function of checking the work of other technicians, or other disciplinary action by the institutional pharmacy or hospital against the designated technician connected with the technician's performance of the technician's duties in the technician-checking-technician program. ( )

e. Each pharmacy technician designated by the institutional pharmacy to perform the function of checking the work of other technicians shall wear a form of identification identifying him as a pharmacy technician so designated, the manner of identification to be as described in the institutional pharmacy's written program description filed with the Board. ( )

f. The institutional pharmacy shall designate a licensed pharmacist, which may be the institutional pharmacy's pharmacist-in-charge, as the technician-checking-technician program coordinator, whose duties as program coordinator shall include the direct supervision of pharmacy technicians designated by the institutional pharmacy to perform the function of checking the work of other technicians, and such other duties as specified in the institutional pharmacy's written program description filed with the Board. ( )

g. The pharmacist-in-charge of the institutional pharmacy shall be responsible for the overall operation of the institutional pharmacy's technician-checking-technician program; for ensuring that the activities of pharmacy technicians in performing the function of checking the work of other technicians are performed completely, safely, and without risk of harm to patients; and for compliance by the institutional pharmacy and its staff with the Board's rules regarding the Pilot Technician-Checking-Technician Program. ( )

05. Duration of Authorization. Authorization for an institutional pharmacy to conduct a pilot technician-checking-technician program shall not exceed two (2) years and shall be subject to the right of the Board and its executive director to conduct an annual review of the institutional pharmacy's technician-checking-technician program. ( )

27~~0~~1. -- 290. (RESERVED).

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-0705

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2008 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 37-2726(4) and 54-1717, 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 Book 2 of the October 3, 2007 Idaho Administrative Bulletin, Vol. 07-10, pages 200 through 202.

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 Jan Atkinson, Senior Compliance Officer, (208) 334-2356.

DATED this 29th day of October, 2007.

Jan Atkinson
Senior Compliance Officer
Idaho Board of Pharmacy
3380 Americana Terrace, Ste. 320
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
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IDAHO STATE BOARD OF PHARMACY ***Docket No. 27-0101-0705***
Rules of the Idaho State Board of Pharmacy ***PENDING RULE***

THE FOLLOWING NOTICE 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 37-2726(4) and 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2007.

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 Board of Pharmacy is instituting a 24/7 electronic database for tracking controlled substance prescriptions. The rule is needed to comply with the directive of Section 37-2726(4), Idaho Code, that the Board promulgate rules to insure that only authorized individuals have access to the database.

The proposed rule establishes procedures for registration in order to access the database; for assignment of user accounts, log-in names, and passwords; for confidentiality; for discipline for the unauthorized disclosure of information or sharing of account information, log-in names, or passwords; and for information reports by non-practitioners.

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 of the simple nature of the rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jan Atkinson, Senior Compliance Officer, (208) 334-2356.

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 24, 2007.

DATED this 15th day of August, 2007.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE

497. INFORMATION FROM CONTROLLED SUBSTANCES PRESCRIPTION DATABASE.

01. **Authority**. These rules are promulgated as authorized by Section 37-2726(4), Idaho Code. ( )

02. **Definitions**. The definitions set forth in Section 37-2701, Idaho Code, shall apply to these rules. ( )

03. **Access to Online Prescription Monitoring Program**. Access to the Idaho Board of Pharmacy's online Prescription Monitoring Program shall be limited to licensed practitioners and licensed pharmacists who have registered with the Board. ( )

04. **Registration and Access Requirements**. In order to register with the Board and obtain access to the online Prescription Monitoring Program, a licensed practitioner or licensed pharmacist must: ( )

a. Complete the registration form available from the Idaho Board of Pharmacy; ( )

b. Obtain from the Board a user account, login name, and password; and ( )

c. Agree in writing that: ( )

i. No information shall be accessed from the Prescription Monitoring Program by a licensed practitioner having authority to prescribe controlled substances unless it relates specifically to a current patient of the practitioner, to whom the practitioner is prescribing or considering prescribing any controlled substance; ( )

ii. No information shall be accessed by a licensed pharmacist having authority to dispense controlled substances from the Prescription Monitoring Program unless it relates specifically to a current patient to whom that pharmacist is dispensing or considering dispensing any controlled substance; ( )

iii. Information accessed from the Prescription Monitoring Program shall be kept confidential; ( )

iv. Information accessed from the Prescription Monitoring Program shall not be disclosed to any unauthorized person; and ( )

v. User account information, login names, and passwords shall not be shared with any person, regardless of whether or not that person is also an authorized user of the online

Prescription Monitoring Program. ( )

05. Conditions on Access and Use. Each of the following conditions applies to access to the online Prescription Monitoring Program and to use of information obtained from it. ( )

a. No licensed practitioner or licensed pharmacist authorized by the Board to access the online Prescription Monitoring Program shall share user account information, login names, or passwords with any person, regardless of whether or not that person is also an authorized user of the online Prescription Monitoring Program. ( )

b. A licensed practitioner having authority to prescribe controlled substances shall access the online Prescription Monitoring Program only to obtain information specifically related to a current patient of the practitioner, to whom the practitioner is prescribing or considering prescribing any controlled substance. ( )

c. A licensed pharmacist having authority to dispense controlled substances shall access the Prescription Monitoring Program only to obtain information specifically related to a current patient to whom that pharmacist is dispensing or considering dispensing any controlled substance. ( )

d. Information obtained from the Prescription Monitoring Program shall be kept confidential. ( )

e. No information obtained from the Prescription Monitoring Program shall be disclosed to any unauthorized person. ( )

f. No information obtained from the Prescription Monitoring Program shall be used for a purpose outside the licensed practitioner's or licensed pharmacist's scope of professional practice. ( )

g. No licensed practitioner or licensed pharmacist shall permit any unauthorized person to utilize the practitioner's or pharmacist's user account, account name, or password in order to access the online Prescription Monitoring Program regarding any person or for any purpose. ( )

06. Termination of Access and Discipline. Violation of these rules shall be grounds for suspension, revocation, or restriction of the licensed practitioner's or licensed pharmacist's authorization to access the online Prescription Monitoring Program; and shall be grounds for discipline of the licensed practitioner or licensed pharmacist and the imposition of penalties pursuant to Sections 54-1726 and 54-1728, Idaho Code. ( )

07. Other Profile Requests. Profiles from the Prescription Monitoring Program may be obtained by those persons authorized by Section 37-2726(2), Idaho Code, to obtain such information, but who are not registered and authorized by the Board for online access, or are not eligible under these rules for registration and online access, by: ( )

a. Completing the form provided by the Idaho Board of Pharmacy and mailing or faxing the completed form, along with any proof of identification and authorization required by

the Board, to the Idaho Board of Pharmacy's office; or ( )

b. By serving upon the Board a lawful order of a court of competent jurisdiction directing the Board to produce the profile to that court or to such person designated by the court in its order. ( )

08. **Additional Grounds for Discipline**. A licensed practitioner or licensed pharmacist who obtains an individual's profile pursuant to Subsection 497.07 of these rules shall be subject to discipline and sanctions pursuant to Sections 54-1726 and 54-1728, Idaho Code, if: ( )

a. The profile was obtained for an individual with whom the practitioner or pharmacist did not have a current practitioner/patient or pharmacist/patient relationship at the time the profile was requested; ( )

b. The profile was requested for an unlawful purpose; ( )

c. The information in the profile was used for an unlawful purpose; or ( )

d. The profile or information from the profile was disclosed by the practitioner or pharmacist to an unauthorized person. ( )

09. **Duties, Powers, and Immunities**. Nothing in these rules shall affect the Idaho Board of Pharmacy's duties and powers under Sections 37-2730a(2) and 37-2730a(3), Idaho Code, or the immunities granted by Section 37-2730a(4), Idaho Code. ( )

49~~7~~8. -- 999. (RESERVED).