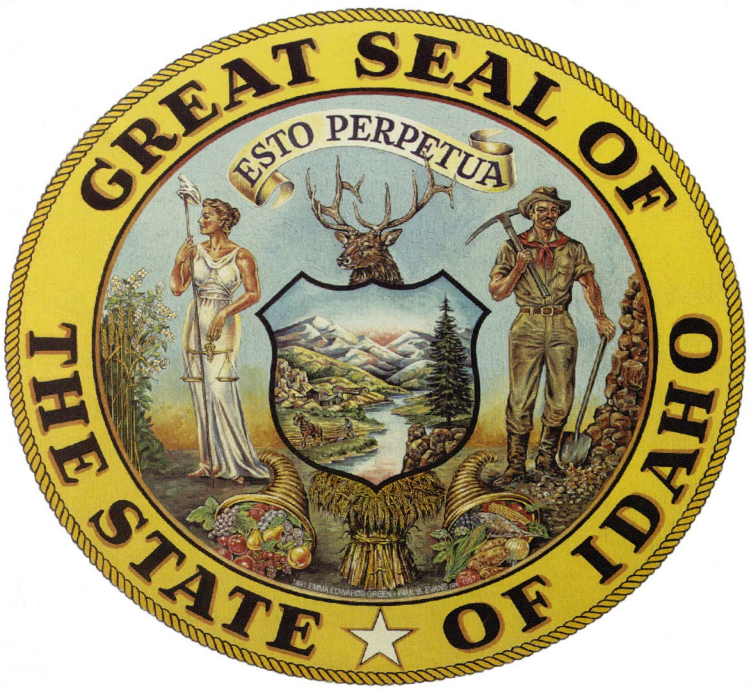
IDAHO ADMINISTRATIVE BULLETIN

November 5, 2025 – Vol. 25-11

Office of the Governor
Division of Financial Management
Office of the Administrative Rules Coordinator



The Idaho Administrative Bulletin is published monthly by the Office of the Administrative Rules Coordinator, Division of Financial Management, Office of the Governor, pursuant to Title 67, Chapter 52, Idaho Code.

IDAHO ADMINISTRATIVE BULLETIN

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PREFACE

The Idaho Administrative Bulletin is an electronic-only, online monthly publication of the Office of the Administrative Rules Coordinator, Division of Financial Management, that is published pursuant to Section 67-5203, Idaho Code. The Bulletin is a compilation of all official rulemaking notices, official rule text, executive orders of the Governor, and all legislative documents affecting rules that are statutorily required to be published in the Bulletin. It may also include other rules-related documents an agency may want to make public through the Bulletin.

State agencies are required to provide public notice of all rulemaking actions and must invite public input. This is done through negotiated rulemaking procedures or after proposed rulemaking has been initiated. The public receives notice that an agency has initiated proposed rulemaking procedures through the Idaho Administrative Bulletin and a legal notice (Public Notice of Intent) that publishes in authorized newspapers throughout the state. The legal notice provides reasonable opportunity for the public to participate when a proposed rule publishes in the Bulletin. Interested parties may submit written comments to the agency or request public hearings of the agency, if none have been scheduled. Such submissions or requests must be presented to the agency within the time and manner specified in the individual "Notice of Rulemaking - Proposed Rule" for each proposed rule that is published in the Bulletin.

Once the comment period closes, the agency considers fully all comments and information submitted regarding the proposed rule. Changes may be made to the proposed rule at this stage of the rulemaking, but changes must be based on comments received and must be a "logical outgrowth" of the proposed rule. The agency may now adopt and publish the pending rule. A pending rule is "pending" legislative review for final approval. The pending rule is the agency's final version of the rulemaking that will be forwarded to the legislature for review and final approval. Comment periods and public hearings are not provided for when the agency adopts a temporary or pending rule.

CITATION TO THE IDAHO ADMINISTRATIVE BULLETIN

The Bulletin is identified by the calendar year and issue number. For example, Bulletin **22-1** refers to the first Bulletin issued in calendar year **2022**; Bulletin **24-1** refers to the first Bulletin issued in calendar year **2024**. Volume numbers, which proceed from 1 to 12 in a given year, correspond to the months of publication, i.e.; Volume No. **22-1** refers to January 2022; Volume No. **24-2** refers to February 2024; and so forth. Example: The Bulletin published in January 2022 is cited as Volume **22-1**. The December 2022 Bulletin is cited as Volume **22-12**.

RELATIONSHIP TO THE IDAHO ADMINISTRATIVE CODE

The **Idaho Administrative Code** is an electronic-only, online compilation of all final and enforceable administrative rules of the state of Idaho that are of full force and effect. Any temporary rule that is adopted by an agency and is of force and effect is codified into the Administrative Code upon Bulletin publication. All pending rules that have been approved by the legislature during the legislative session as final rules and any temporary rules that are extended supplement the Administrative Code. These rules are codified into the Administrative Code upon becoming effective. Because proposed and pending rules are not enforceable, they are published in the Administrative Bulletin only and cannot be codified into the Administrative Code until approved as final.

To determine if a particular rule remains in effect or whether any amendments have been made to the rule, refer to the Cumulative Rulemaking Index. Link to it on the Administrative Rules homepage at adminrules.idaho.gov.

THE DIFFERENT RULES PUBLISHED IN THE ADMINISTRATIVE BULLETIN

Idaho's administrative rulemaking process, governed by the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, comprises distinct rulemaking actions: negotiated, proposed, temporary, pending, and final rulemaking. Not all rulemakings incorporate or require all of these actions. For a rule to become final, at a minimum, a rulemaking includes proposed, pending, and final rulemaking. Some rules may be adopted as temporary rules when they meet the required statutory criteria. Agencies must, when feasible, engage in negotiated rulemaking at the beginning of the process to facilitate consensus building. In some cases, the process may begin with proposed rulemaking and end with the final rulemaking. The following is a brief explanation of each type of rule.

1. NEGOTIATED RULEMAKING

Negotiated rulemaking is a process in which all interested persons and the agency seek consensus on the content of a rule through dialogue. Agencies are required to conduct negotiated rulemaking whenever it is feasible to do so. The agency files a "Notice of Intent to Promulgate – Negotiated Rulemaking" for publication in the Administrative Bulletin inviting interested persons to contact the agency if interested in discussing the agency's intentions regarding the rule changes. This process is intended to result in the formulation of a proposed rule and the initiation of regular rulemaking procedures. One result, however, may also be that regular (proposed) rulemaking is not initiated and no further action is taken by the agency.

2. PROPOSED RULEMAKING

A proposed rulemaking is an action by an agency wherein the agency is proposing to amend or repeal an existing rule or to adopt a new rule. Prior to the adoption, amendment, or repeal of a rule, the agency must publish a "Notice of Rulemaking – Proposed Rule" in the Bulletin. This notice must include very specific information regarding the rulemaking including all relevant state or federal statutory authority occasioning the rulemaking, a non-technical description of the changes being made, any associated costs, guidance on how to participate through submission of written comments and requests for public hearings, and the text of the proposed rule in legislative format.

3. PENDING RULEMAKING

A pending rule is a rule that has been adopted by an agency under regular rulemaking procedures and remains subject to legislative review before it becomes a final, enforceable rule. When a pending rule is published in the Bulletin, the agency is required to include certain information in the "Notice of Rulemaking – Pending Rule." This includes a statement giving the reasons for adopting the rule, a statement regarding when the rule becomes effective, a description of how it differs from the proposed rule, and identification of any fees being imposed or changed.

Agencies are required to republish the text of the pending rule when substantive changes have been made to the proposed rule. An agency may adopt a pending rule that varies in content from that which was originally proposed if the subject matter of the rule remains the same, the pending rule change is a logical outgrowth of the proposed rule, and the original notice was written so as to assure that members of the public were reasonably notified of the subject. It is not always necessary to republish all the text of the pending rule.

4. FINAL RULEMAKING

A final rule is a rule that has been adopted by an agency under the regular rulemaking procedures, has been approved by the legislature, and is of full force and effect.

5. TEMPORARY RULEMAKING

Temporary rules may be adopted only when the governor finds that it is necessary for:

a) protection of the public health, safety, or welfare; or
b) compliance with deadlines in amendments to governing law or federal programs; or
c) reducing a regulatory burden that would otherwise impact individuals or businesses.

If a rulemaking meets one or more of these criteria, and with the Governor's approval, the agency may adopt and make a temporary rule effective prior to receiving legislative authorization and without allowing for any public input. The law allows an agency to make a temporary rule immediately effective upon adoption. A temporary rule expires at the conclusion of the next succeeding regular legislative session unless the rule is extended by concurrent resolution, is replaced by a final rule, or expires under its own terms.

Agencies must concurrently promulgate a temporary rule and a proposed rule when the text of the two rulemakings is the same, unless the temporary rule will expire before a proposed rule could become final.

HOW TO USE THE IDAHO ADMINISTRATIVE BULLETIN

Rulemaking documents produced by state agencies and published in the **Idaho Administrative Bulletin** are organized by a numbering schematic. Each state agency has a two-digit identification code number known as the **"IDAPA"** number. (The "IDAPA" Codes are listed in the alphabetical/numerical index at the end of this Preface.) Within each agency there are divisions or sections to which a two-digit "TITLE" number is assigned. There are "CHAPTER" numbers assigned within the Title and the rule text is divided among major sections that are further subdivided into subsections. An example IDAPA number is as follows:

IDAPA 38.05.01.041.02.c.ii.

"IDAPA" refers to Administrative Rules in general that are subject to the Administrative Procedures Act and are required by this act to be published in the Idaho Administrative Code and the Idaho Administrative Bulletin.

"38." refers to the Idaho Department of Administration

"05." refers to Title **05**, which is the Department of Administration's Division of Purchasing

"01." refers to Chapter **01** of Title 05, "Rules of the Division of Purchasing"

"041." refers to Major Section **041**, "Acquisition Procedures"

"02." refers to Subsection 041.**02**.

"**c.**" refers to Subsection 041.02.**c**.

"ii." refers to Subsection 041.02.c.**ii**.

DOCKET NUMBERING SYSTEM

Internally, the Bulletin is organized sequentially using a rule docketing system. Each rulemaking that is filed with the Coordinator is assigned a "DOCKET NUMBER." The docket number is a series of numbers separated by a hyphen "-", (**38-0501-2201**). Rulemaking dockets are published sequentially by IDAPA number (the two-digit agency code) in the Bulletin. The following example is a breakdown of a typical rule docket number:

"DOCKET NO. 38-0501-2201"

"38-" denotes the agency's **IDAPA** number; in this case the Department of Administration.

"0501-" refers to the **TITLE AND CHAPTER** numbers of the agency rule being promulgated; in this case the Division of Purchasing (TITLE **05**), Rules of the Division of Purchasing (Chapter **01**).

"2201" denotes the year and sequential order of the docket being published; in this case the numbers refer to the first rulemaking action published in **calendar year 2022**. A subsequent rulemaking on this same rule chapter in calendar year 2022 would be designated as "**2202**". The docket number in this scenario would be 38-0501-**2202**.

Within each Docket, only the affected sections of chapters are printed. (See **Sections Affected Index** in each Bulletin for a listing of these.) The individual sections affected are printed in the Bulletin sequentially (e.g. Section "200" appears before Section "345" and so on). Whenever the sequence of the numbering is broken, the following statement will appear:

(BREAK IN CONTINUITY OF SECTIONS)

RULEMAKING DEADLINES CY 2025

BULLETIN MONTH / VOL.	FEB 25-2	MAR 25-3	APR 25-4	MAY 25-5	JUN 25-6	JUL 25-7	AUG 25-8	SEPT 25-9	OCT 25-10	NOV 25-11	DEC 25-12	JAN '26 26-1
ARRF DUE	Dec 20	Jan 24	Feb 21	Mar 21	April 18	May 23	June 20	July 18	Aug 15	Sept 19	Oct 24	Nov 21
AGENCY FILING DUE	Jan 3	Feb 7	Mar 7	April 4	May 2	June 6	July 3	Aug 1	***Aug 29**	Oct 3	Nov 7	****Dec 5**
BULLETIN PUBLISHED	Feb 5	Mar 5	April 2	May 7	June 4	July 2	Aug 6	Sept 3	Oct 1	Nov 5	Dec 3	Jan 7
21-DAY COMMENT ENDS	Feb 26	Mar 5	April 23	May 28	June 25	July 23	Aug 27	Sept 24	Oct 22	Nov 26	Dec 24	Jan 28

August 29, 2025: Last day to submit a Proposed Rule for the upcoming Legislature

****December 5, 2025: Last day to submit a Pending Rule for the upcoming Legislature***

RULEMAKING DEADLINES CY 2026

BULLETIN MONTH / VOL.	FEB 26-2	MAR 26-3	APR 26-4	MAY 26-5	JUN 26-6	JUL 26-7	AUG 26-8	SEPT 26-9	OCT 26-10	NOV 26-11	DEC 26-12	JAN '27 27-1
ARRF DUE	Dec 26	Jan 23	Feb 20	March 20	April 17	May 15	June 19	July 17	Aug 14	Sept 18	Oct 16	Nov 20
AGENCY FILING DUE	Jan 9	Feb 6	Mar 6	April 3	May 1	May 29	July 3	July 31	***Aug 28**	Oct 2	Oct 30	****Dec 4**
BULLETIN PUBLISHED	Feb 4	Mar 4	April 1	May 6	June 3	July 1	Aug 5	Sept 2	Oct 7	Nov 4	Dec 2	Jan 6
21-DAY COMMENT ENDS	Feb 25	Mar 25	April 22	May 27	June 24	July 22	Aug 26	Sept 23	Oct 28	Nov 25	Dec 23	Jan 27

August 28, 2026: Last day to submit a Proposed Rule for the upcoming Legislature

****December 4, 2026: Last day to submit a Pending Rule for the upcoming Legislature***

Access to DFM's Administrative Rules Request Form (ARRF)

Access the Idaho Rule Writer's Manual

ALPHABETICAL INDEX OF STATE AGENCIES AND CORRESPONDING IDAPA NUMBERS

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IDAPA 20	**Lands**, Idaho Department of
IDAPA 52	**Lottery Commission**, Idaho State
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ALPHABETICAL INDEX OF STATE AGENCIES AND CORRESPONDING IDAPA NUMBERS

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IDAPA 47	**Vocational Rehabilitation**, Division of
IDAPA 37	**Water Resources**, Department of
IDAPA 42	**Wheat Commission**, Idaho

Executive Department
State of Idaho

State Capitol
Boise

EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE

EXECUTIVE ORDER NO. 2025-06

CREATION OF THE IDAHO ADVANCED NUCLEAR ENERGY TASK FORCE

WHEREAS, Idaho is committed to supporting President Donald Trump's vision for America's Nuclear Renaissance in order to secure our nation's energy dominance and protect our national interests; and

WHEREAS, the State of Idaho is home to the Idaho National Laboratory (INL), a global leader in nuclear energy research, development, and demonstration; and

WHEREAS, energy reliability, affordability, and environmental stewardship are essential to Idaho's economic prosperity and quality of life; and

WHEREAS, advanced nuclear energy technologies, including small modular reactors (SMRs) and next-generation reactors, offer promising solutions to meet Idaho's growing energy needs while supporting emissions reduction goals; and

WHEREAS, strategic planning and collaboration among industry, academia, and government is necessary to ensure Idaho remains at the forefront of nuclear innovation;

NOW, THEREFORE, I, Brad Little, Governor of the State of Idaho, by the authority vested in me by the Constitution and laws of the State of Idaho, do hereby order the following:

1. *There is hereby established the Idaho Advanced Nuclear Energy Task Force ("Task Force") to assess, recommend, and support strategies that advance Idaho's leadership in nuclear energy innovation, deployment, and workforce development.*

2. *The Task Force shall advise the Governor on nuclear energy policy including but not limited to the following topics:*
   a. *Spent nuclear fuel*
   b. *Legislative and regulatory reforms that would facilitate the timely and safe development of advanced nuclear projects*
   c. *Energy resiliency and security*
   d. *Fuel creation, enhancement and minimization*
   e. *Letters of support for federal agencies, funding opportunities, and project initiatives*
   f. *Policy recommendations on legacy, current, and emerging nuclear issues*
   g. *Opportunities for Idaho to collaborate with other nuclear-advanced states*
   h. *Strategic outreach and recruitment of companies and partnerships that can help expand Idaho's nuclear economy*

3. *Coordinate with other state task forces and advisory boards and other national partners to keep the Governor informed of nuclear policy shifts, technological breakthroughs, and cross-jurisdictional opportunities.*

4. *Develop or direct the creation of marketing materials that position Idaho as a national hub for nuclear innovation, research, and private-sector development.*

5. *Stay informed on and provide updates to the Governor on:*
   a. *Ongoing research and developments at INL*
   b. *National trends and policy updates in nuclear energy*
   c. *Current nuclear industry issues and innovations*
   d. *Cleanup progress and legacy waste issues*
   e. *Companies interested in operating or investing in Idaho*

6. *Meet quarterly with the Governor and at his discretion*

7. *Report on the activities of the NUCLEAR EDUCATION AND PUBLIC ENGAGEMENT SUBCOMMITTEE and coordinate closely with its broader efforts.*

8. *Evaluate the feasibility and benefits of deploying advanced nuclear technologies within the State of Idaho, including but not limited to small modular reactors, microreactors, and molten salt reactors.*

9. *Identify public-private partnership opportunities to support research, commercialization, and deployment of nuclear technologies.*

10. *Coordinate with the Idaho National Laboratory, universities, utilities, industry stakeholders, and federal agencies to align state policy with national innovation efforts.*

11. *Explore workforce development initiatives, including training programs and academic partnerships, to support a growing nuclear industry.*

12. *Report findings and recommendations to the Governor annually, with subsequent updates as necessary.*

The Task Force shall be comprised of no more than 20 members appointed by the Governor and may include:

- *A Constitutional Officer of the State of Idaho;*
- *The Idaho Attorney General or a designee chosen by the Attorney General;*
- *The Director of the Idaho Department of Commerce or a designee chosen by the Director;*
- *The Lab Director of Idaho National Laboratory or a designee chosen by the Director;*
- *A staff member of the Office of the Governor;*
- *The Director of the Idaho Department of Environmental Quality or a designee chosen by the Director;*
- *The Administrator of the Idaho Office of Energy and Mineral Resources or a designee chosen by the Administrator;*
- *The President of the Idaho Public Utilities Commission or a designee chosen by the President;*
- *Electric Utilities doing business in Idaho*
- *Representatives from private-sector nuclear industry*
- *Representatives from Idaho colleges and universities*
- *Two representatives from the Idaho Senate;*
- *Two representatives from the Idaho House of Representatives*
- *Local governments*
- *The Executive Director of the Workforce Development Council or a designee chosen by the Executive Director; and*
- *A representative of a federally recognized Indian Tribe located within the state.*

The Governor will appoint the co-chairs of the task force.

A subcommittee of the Idaho Advanced Nuclear Energy Task Force is hereby established and shall be known as the Nuclear Education and Public Engagement Subcommittee ("Subcommittee").

A. Purpose
The purpose of the Subcommittee is to promote transparent, accurate, and accessible public education about nuclear energy and to foster informed community engagement throughout Idaho.

B. Responsibilities
The Subcommittee shall:

1. *Develop educational programs and materials on nuclear energy fundamentals, safety, environmental impacts, technological advances, and economic benefits;*
2. *Engage with Idaho schools, universities, community colleges, and libraries to integrate nuclear science and energy topics into public curricula and community learning opportunities;*
3. *Organize public forums, listening sessions, and informational campaigns to provide Idahoans with opportunities to learn about and discuss nuclear energy;*
4. *Support partnerships with local media, tribal nations, community groups, and faith-based organizations to ensure equitable access to nuclear education;*
5. *Identify strategies to address public concerns, misinformation, and historical perceptions related to nuclear power and waste management;*
6. *Coordinate outreach efforts with state agencies, INL, academic institutions, and the private sector to amplify educational efforts across platforms.*

C. Membership
The Subcommittee shall include members appointed by the Governor or Task Force Chair and may include representatives from:

- *The Idaho Department of Commerce*
- *Idaho National Laboratory public outreach and education staff*
- *K–12 and higher education institutions*
- *Science communication professionals*
- *A representative of a federally recognized Indian Tribe located within the state with education expertise*
- *Public information officers from relevant state agencies*
- *Community organizations and nonprofits focused on science, energy, or environment*

D. Reporting
The Subcommittee shall provide a progress report to the Task Force every six months and contribute to the Task Force's final report to the Governor and Legislature.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this 22nd day of September in the year of our Lord two thousand and twenty-five.

BRAD LITTLE
GOVERNOR

PHIL MCGRANE
SECRETARY OF STATE

Executive Department
State of Idaho

State Capitol
Boise

EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE

EXECUTIVE ORDER NO. 2025-07

DEFERRED COMPENSATION PROGRAM FOR EMPLOYEES OF THE STATE OF IDAHO; REPEALING AND REPLACING EXECUTIVE ORDER NO. 2021-09

WHEREAS, the Idaho Legislature, by and through the implementation of section 59-513, Idaho Code, has provided for the establishment of a Deferred Compensation Program; and

WHEREAS, a Deferred Compensation Program has been presented to and approved by the Board of Examiners of the State of Idaho by the Deferred Compensation Committee; and

WHEREAS, administrative entities on the state level are necessary for proper implementation and maintenance of the plan;

NOW, THEREFORE, I, Brad Little, the duly elected and sworn Governor of the State of Idaho, by virtue of the authority vested in me under the Constitution and the laws of the State of Idaho, do hereby order the following:

1. *The Deferred Compensation Committee - comprised of a representative appointed by the Governor, a representative from the Office of the Attorney General, a representative from the Office of the State Controller, and a representative from the Office of the Secretary of State-is hereby named as the policymaking board for a Deferred Compensation Program subject to the authority vested by law in the Board of Examiners of the State of Idaho.*

2. *The Deferred Compensation Committee shall make the following decisions concerning the implementation and maintenance of a Deferred Compensation Program subject to the approval of the Board of Examiners:*

    a. *Selection of a third-party administrator to administer the state's 457 plan, including a Roth option;*
    b. *Selection of product companies that sell or offer securities or other assets to the State of Idaho in accordance with a Deferred Compensation Program;*
    c. *Approval and monitoring of the marketing program to introduce and explain the Deferred Compensation Program to state employees;*
    d. *Review all summary reports produced by the Office of the State Controller and the third-party administrator to ensure proper accounting for all funds;*
    e. *Review on a yearly basis the viability of all product companies associated with the Deferred Compensation Program to determine if re-bidding is necessary.*

3. *The Deferred Compensation Committee, through the third-party administrator, shall:*

    a. *Ensure that remittances of deferred moneys to the product companies are made from the periodic payroll;*
    b. *Review and sign all enrollments, change and claim requests;*
    c. *Keep or arrange to keep any necessary files concerning the Deferred Compensation Program;*
    d. *Communicate with the state employees concerning routine matters.*

This Executive Order shall cease to be in effect four years after its entry into force.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this 8th day of October in the year of our Lord two thousand and twenty-five.

BRAD LITTLE
GOVERNOR

PHIL MCGRANE
SECRETARY OF STATE

Executive Department
State of Idaho

State Capitol
Boise

EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE

EXECUTIVE ORDER NO. 2025-08

MAKING RURAL IDAHO HEALTHY AGAIN ACT

WHEREAS, on July 4, 2025, President Donald J. Trump signed the One Big Beautiful Bill Act, P.L. 119-21, preventing a massive tax increase on all Americans, further cutting taxes, shrinking the size and scope of the federal government, and making historic investments in rural health with the creation of the Rural Health Transformation Program (RHTP); and

WHEREAS, the RHTP fund set aside $50 billion nationally, and potentially exceeding $1 billion for Idaho, over the next five (5) years to make rural America healthy again, provide sustainable access to rural residents, develop the rural health workforce, implement innovative care models, and adopt technology innovations; and

WHEREAS, while RHTP is a significant investment and will improve health in rural Idaho, it is also timebound, and Idaho must prudently use this limited resource without creating future state obligations after federal funding sunsets;

NOW, THEREFORE, I, Brad Little, Governor of the State of Idaho, by virtue of the authority vested in me under the Constitution and the laws of the State of Idaho, do hereby order that:

1. *The Idaho Rural Health Taskforce is created and authorized to advise on the application of the RHTP in Idaho.*

2. *The Task Force shall consist of nine (9) members. The Task Force's membership shall be as follows:*
   a. *Ex Officio Members:*
      i. *The Director of the Idaho Department of Health and Welfare (DHW) or designee;*
      ii. *The Adjutant General of the Idaho Military Division or designee;*
      iii. *The Executive Director of the Idaho State Board of Education;*
      iv. *The Executive Director of the Idaho Workforce Development Council;*
      v. *The Co-Chairmen of the Joint Finance-Appropriations Committee, who shall serve on the task force during their legislative terms of office; and*
      vi. *The Chairmen of the Senate Health and Welfare Committee and House Health and Welfare Committee, who shall serve on the task force during their legislative terms of office;*
   b. *Member appointed by the Governor:*
      i. *One (1) representative of an Idaho tribal nation;*

3. *The Director of DHW or designee shall serve as chair of the Task Force.*

4. *The Task Force shall receive administrative support from DHW.*

5. *It is the intent of the Governor that the Task Force sunset on the expiration of this order under law. Therefore, the Task Force shall coordinate with the leadership of rural stakeholders to carry out this order, transform rural health care in Idaho, and improve the lives of Idahoans.*

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Idaho at the Capitol in Boise on this 17th day of October, in the year of our Lord two thousand and twenty-five.

BRAD LITTLE
GOVERNOR

PHIL MCGRANE
SECRETARY OF STATE

IDAPA 02 – DEPARTMENT OF AGRICULTURE

02.06.09 – RULES GOVERNING INVASIVE SPECIES AND NOXIOUS WEEDS

DOCKET NO. 02-0609-2502

NOTICE OF RULEMAKING – ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 24, 2025.

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 22-1907, 22-2004, 22-2006, 22-2403, and 22-2412, Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

The purpose of this temporary rule is two-fold. First, to remove the previous prohibition of watercraft from the treatment area for Quagga mussel on the Snake River from Hansen Bridget to Pillar Falls.

Second, add Golden mussel to the Emergency Detection Rapid Response (EDRR) Invasive Species list. Golden mussel is an aggressive bivalve aquatic mussel that has been found in California water delivery systems. Infestations have already impacted on the delivery of water for irrigation and municipal use, and treatment efforts are already underway. Golden mussel presents significant challenges in potential spread and establishment beyond that found with the current quagga mussel infestation found in Idaho. Adding Golden mussel to the EDRR list ensures adequate legal authority for prevention and response efforts in Idaho.

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

Both changes deal with actions that require immediate action. The lifting of the ban on watercraft to the Snake River Quagga Mussel treatment area ensures that restrictions are not in place longer than necessary. The addition of Golden mussel to the EDRR list ensures the protection of public health and safety and ensures that the department can prevent and respond to infestations that would seriously impact the ability to deliver and utilize water in Idaho.

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:

No fee is being imposed or changed because of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Lloyd Knight at (208)332-8615 or lloyd.knight@isda.idaho.gov.

DATED this 24th day of October, 2025.

Lloyd B. Knight
Deputy Director
Idaho State Department of Agriculture
2270 Old Penitentiary Road
Boise, ID 83712
(208)332-8615
Email: Lloyd.knight@isda.idaho.gov

THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE FOR DOCKET NO. 02-0609-2502
(Only Those Sections With Amendments Are Shown.)

02.06.09 – RULES GOVERNING INVASIVE SPECIES AND NOXIOUS WEEDS

130. EARLY DETECTION AND RAPID RESPONSE AQUATIC INVERTEBRATE INVASIVE SPECIES.

01. Statewide EDRR AIIS List. If any of the species listed in the following table are found to occur in Idaho, they shall be reported to the Department immediately. Positive identification will be made by the Department or other qualified authority as approved by the Director. Subsections 130.02 through 130.05 are applicable to EDRR AIIS only and not to other invasive species listed in Sections 140 through 148.

Early Detection Rapid Response Aquatic Invertebrate Invasive Species (EDRR AIIS) List	
Common Name	**Scientific Name**
Quagga Mussel	*Dreissena bugensis*
Zebra Mussel	*Dreissena polymorpha*
Golden Mussel	*Limnoperna forunei*

~~(3-15-22)~~(10-24-25)T

02. Transporting EDRR AIIS Over Public Roads. No person may transport Equipment or any Conveyance containing EDRR AIIS over public roads within the state of Idaho without first being decontaminated. (3-15-22)

03. Contaminated Conveyances in Idaho Waters. No person may place any EDRR AIIS contaminated Equipment or Conveyance into any Water Body or Water Supply System in the state of Idaho. (3-15-22)

04. Firefighting Equipment. Precautions should be taken to prevent the introduction and spread of EDRR AIIS through firefighting activities. All firefighting agencies moving equipment into the state of Idaho shall follow protocols similar to the United States Forest Service decontamination protocols set forth in "Guide to Preventing Aquatic Invasive Species Transport by Wildland Fire Operations." Those protocols can be viewed online at https://www.fs.usda.gov/Internet/FSE_DOCUMENTS/stelprdb5373422.pdf. (7-1-24)

05. Construction and Road Building and Maintenance Equipment. Construction and equipment used for road building and maintenance must be free of EDRR AIIS. If equipment that is being transported into the state of Idaho has been in an infested water body or water supply system within the preceding thirty (30) days, the equipment must be inspected in accordance with Section 132. The Department may require decontamination. (3-15-22)

(BREAK IN CONTINUITY OF SECTIONS)

135. SNAKE RIVER QUARANTINE.

ISDA has issued a quarantine of the Snake River from Hansen Bridge to the partial bridge structure at the bottom of Yingst Grade (known as "the Broken Bridge", "Yingst Grade Bridge", the "Old Interstate Bridge"), which is approximately one-half (1/2) mile upstream of Auger Falls to contain and treat quagga mussels. Launch of watercraft or other conveyances in this section is restricted to the hours when the watercraft inspection station at Centennial Waterfront Park is open, or other such stations that may be posted at other locations in the quarantine area. All watercraft and conveyances must be inspected and decontaminated by agency personnel or an assigned entity prior to launch and prior to exit from the water. This requirement applies to all motorized and non-motorized watercraft or other conveyances of any size, including paddle boards, kayaks, and water-exposed recreational gear. ~~Effective September 29, 2025, access to the river by watercraft or other conveyances of any size, including paddle boards, kayaks, and water-exposed recreation gear is prohibited between Hansen Bridge and Pillar Falls. The prohibition will remain in effect unless amended by the Director at the conclusion of the active treatment and dissipation period.~~

~~(9-29-25)T~~(10-24-25)T

136. -- 139. (RESERVED)

140. INVASIVE SPECIES - AQUATIC INVERTEBRATES.

INVASIVE SPECIES - AQUATIC INVERTEBRATES		
	Common Name	**Scientific Name**
01.	**Zebra Mussel**	*Dreissenia polymorpha*
02.	**Quagga Mussel**	*Dreissenia bugensis*
03.	**New Zealand Mud Snail**	*Potamopyrgus antipodarum*
04.	**Red Claw Crayfish**	*Cherax quadricarinatus*
05.	**Yabby Crayfish**	*Cherax albidus/C. destructor*
06.	**Marone Crayfish**	*Cherax tenuimanus*
07.	**Marbled Crayfish**	*Procambarus fallax f. virginalis*
08.	**Rusty Crayfish**	*Faxonius rusticus*
09.	**Asian Clam**	*Corbicula fluminea*
10.	**Spiny Waterflea**	*Bythotrephes cederstroemi*
11.	**Fishhook Waterflea**	*Cercopagis pengoi*
12.	**Marmorkrebs**	*Procambarus sp.*
13.	**Golden Mussel**	*Limnoperna forunei*

~~(3-15-22)~~(10-24-25)T

IDAPA 02 – DEPARTMENT OF AGRICULTURE

02.06.09 – RULES GOVERNING INVASIVE SPECIES AND NOXIOUS WEEDS

DOCKET NO. 02-0609-2503

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 22-1907, 22-2004, 22-2006, 22-2403, and 22-2412, Idaho Code.

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

Monday, November 17, 2025
10:00am – 11:00am

Idaho State Department of Agriculture
2270 Old Penitentiary Road
Boise, ID 83714

Join by Virtual Meeting link found here
Or on www.townhall.idaho.gov

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 purpose of this proposed rule is two-fold. First, to remove the previous prohibition of watercraft from the treatment area for Quagga mussel on the Snake River from Hansen Bridget to Pillar Falls.

Second, add Golden mussel to the Emergency Detection Rapid Response (EDRR) Invasive Species list. Golden mussel is an aggressive bivalve aquatic mussel that has been found in California water delivery systems. Infestations have already impacted on the delivery of water for irrigation and municipal use, and treatment efforts are already underway. Golden mussel presents significant challenges in potential spread and establishment beyond that found with the current quagga mussel infestation found in Idaho. Adding Golden mussel to the EDRR list ensures adequate legal authority for prevention and response efforts in Idaho.

Additionally, These rules mirror the temporary rule in Docket No. 02-0609-2502, which was immediately needed to protect public health and safety and reduce a regulatory burden.

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

No fee is being imposed or changed because of this rulemaking.

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

There is no fiscal impact on the General Fund or dedicated funds because of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not feasible to conduct because of the immediate need to release the quarantine on the treatment area

to allow access to the river. In addition, it was not feasible because the department needs the immediate listing of Golden mussel to ensure authority for prevention efforts, including watercraft inspection.

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

No materials are incorporated by reference.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Lloyd Knight at (208)332-8615 or Lloyd.knight@isda.idaho.gov.

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 November 26, 2025.

DATED this 5th day of November, 2025.

Lloyd B. Knight
Deputy Director
Idaho State Department of Agriculture
2270 Old Penitentiary Road
Boise, ID 83712
(208)332-8615
Email: Lloyd.knight@isda.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 02-0609-2503
(Only Those Sections With Amendments Are Shown.)

02.06.09 – RULES GOVERNING INVASIVE SPECIES AND NOXIOUS WEEDS

130. EARLY DETECTION AND RAPID RESPONSE AQUATIC INVERTEBRATE INVASIVE SPECIES.

01. Statewide EDRR AIIS List. If any of the species listed in the following table are found to occur in Idaho, they shall be reported to the Department immediately. Positive identification will be made by the Department or other qualified authority as approved by the Director. Subsections 130.02 through 130.05 are applicable to EDRR AIIS only and not to other invasive species listed in Sections 140 through 148.

Early Detection Rapid Response Aquatic Invertebrate Invasive Species (EDRR AIIS) List	
Common Name	**Scientific Name**
Quagga Mussel	*Dreissena bugensis*
Zebra Mussel	*Dreissena polymorpha*
Golden Mussel	Linoperna forunei

~~(3-15-22)~~( )

02. Transporting EDRR AIIS Over Public Roads. No person may transport Equipment or any Conveyance containing EDRR AIIS over public roads within the state of Idaho without first being decontaminated. (3-15-22)

03. Contaminated Conveyances in Idaho Waters. No person may place any EDRR AIIS contaminated Equipment or Conveyance into any Water Body or Water Supply System in the state of Idaho. (3-15-22)

04. Firefighting Equipment. Precautions should be taken to prevent the introduction and spread of EDRR AIIS through firefighting activities. All firefighting agencies moving equipment into the state of Idaho shall follow protocols similar to the United States Forest Service decontamination protocols set forth in "Guide to Preventing Aquatic Invasive Species Transport by Wildland Fire Operations." Those protocols can be viewed online at https://www.fs.usda.gov/Internet/FSE_DOCUMENTS/stelprdb5373422.pdf. (7-1-24)

05. Construction and Road Building and Maintenance Equipment. Construction and equipment used for road building and maintenance must be free of EDRR AIIS. If equipment that is being transported into the state of Idaho has been in an infested water body or water supply system within the preceding thirty (30) days, the equipment must be inspected in accordance with Section 132. The Department may require decontamination. (3-15-22)

(BREAK IN CONTINUITY OF SECTIONS)

135. SNAKE RIVER QUARANTINE.
ISDA has issued a quarantine of the Snake River from Hansen Bridge to the partial bridge structure at the bottom of Yingst Grade (known as "the Broken Bridge", "Yingst Grade Bridge", the "Old Interstate Bridge"), which is approximately one-half (1/2) mile upstream of Auger Falls to contain and treat quagga mussels. Launch of watercraft or other conveyances in this section is restricted to the hours when the watercraft inspection station at Centennial Waterfront Park is open, or other such stations that may be posted at other locations in the quarantine area. All watercraft and conveyances must be inspected and decontaminated by agency personnel or an assigned entity prior to launch and prior to exit from the water. This requirement applies to all motorized and non-motorized watercraft or other conveyances of any size, including paddle boards, kayaks, and water-exposed recreational gear. ( )

1356. – 139. (RESERVED)

140. INVASIVE SPECIES - AQUATIC INVERTEBRATES.

INVASIVE SPECIES - AQUATIC INVERTEBRATES		
	Common Name	**Scientific Name**
01.	**Zebra Mussel**	Dreissenia polymorpha
02.	**Quagga Mussel**	Dreissenia bugensis
03.	**New Zealand Mud Snail**	Potamopyrgus antipodarum
04.	**Red Claw Crayfish**	Cherax quadricarinatus
05.	**Yabby Crayfish**	Cherax albidus/C. destructor
06.	**Marone Crayfish**	Cherax tenuimanus
07.	**Marbled Crayfish**	Procambarus fallax f. virginalis
08.	**Rusty Crayfish**	Faxonius rusticus

INVASIVE SPECIES - AQUATIC INVERTEBRATES		
	Common Name	**Scientific Name**
09.	**Asian Clam**	Corbicula fluminea
10.	**Spiny Waterflea**	Bythotrephes cederstroemi
11.	**Fishhook Waterflea**	Cercopagis pengoi
12.	**Marmorkrebs**	Procambarus sp.
13.	**Golden Mussel**	Limnoperna forunei

~~(3-15-22)~~( )

IDAPA 11 – IDAHO STATE POLICE
IDAHO PUBLIC SAFETY AND SECURITY INFORMATION SYSTEM

11.10.01 – RULES GOVERNING IDAHO PUBLIC SAFETY AND SECURITY INFORMATION SYSTEM

DOCKET NO. 11-1001-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 19-5201-5204, 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:

ISP initiated this rulemaking in compliance with Executive Order No. 2020-01 Zero-Based Regulation issued by Governor Little. Pursuant to the order, ISP performed a comprehensive review of the chapter to reduce the regulatory burden and increase clarity.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025 Idaho Administrative Bulletin, Vol. 25-8, pages 15-25.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Bureau Chief Leila McNeill at (208) 884-7136, email Leila.mcneill@isp.idaho.gov.

DATED this 29th day of September, 2025.

Lieutenant Colonel Russ Wheatley, Chief of Staff
Idaho State Police
700 S Stratford Drive
Meridian ID 83642
(208) 884-7004
Russ.wheatley@isp.idaho.gov

IDAPA 11 – IDAHO STATE POLICE

11.10.03 – RULES GOVERNING THE SEX OFFENDER REGISTRY

DOCKET NO. 11-1003-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 18-8301-18-8331, 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:

ISP initiated this rulemaking in compliance with Executive Order No. 2020-01 Zero-Based Regulation issued by Governor Little. Pursuant to the order, ISP performed a comprehensive review of the chapter to reduce the regulatory burden and increase clarity.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 30-33.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Bureau Chief, Leila McNeill, (208) 884-7136, email- Leila.mcneill@isp.idaho.gov.

DATED this 15th day of September, 2025.

Lieutenant Colonel Russ Wheatley
Chief of Staff
Idaho State Police
700 S Stratford Drive
Meridian ID 83642
(208) 884-7004
Russ.wheatley@isp.idaho.gov

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.13 – CONSUMER-DIRECTED SERVICES

DOCKET NO. 16-0313-2501 (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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 Sections 56-203, 56-250 through 56-257, and 56-260 through 56-266, 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:

When HB345 was passed during the 2025 Legislative Session, Medicaid chapter 16.03.13 was inadvertently left out of the rule repeal section. To prevent the existence of a separate independent chapter, this chapter is being repealed and consolidated into Docket 16-0326-2501, also published in this bulletin.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 3, 2025, Idaho Administrative Bulletin, Vol. 25-9, pages 15-16.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

Fees will not be increased by the elimination of this chapter.

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 will not be an impact to the general fund greater than $10,000.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at DHWRules@dhw.idaho.gov or (208) 334-5500.

DATED this 5th day of November, 2025.

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

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.26 – MEDICAID PLAN BENEFITS

DOCKET NO. 16-0326-2501 (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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eight Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 56-202(b), and 56-265, 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:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The final provisions of House Bill 345 of the 2025 Idaho Legislative Session eliminated several chapters of administrative rule related to Medicaid. Pending rule 16.03.26, Medicaid Plan Benefits, incorporated components of chapters eliminated by House Bill 345 including 16.03.09 and 16.03.10 into a single chapter that was adopted as a temporary rule and took effect July 1, 2025. Additionally, the Department is proposing to repeal chapter 16.03.13 via docket 16-0313-2501. Pending rule 16.03.26, Medicaid Plan Benefits, has been amended to make technical corrections, as logical outgrowth of public comments, and to incorporate components of 16.03.13, Consumer Directed Services, to combine all Medicaid chapters into one.

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 June 4, 2025, Idaho Administrative Bulletin, Vol. 25-6, pages 175 through 335. The complete text of chapter 16.03.13, Consumer Directed Services, was published in the September 4, 2024, Idaho Administrative Bulletin, Vol. 24-9, pages 303 through 334.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Fees will not be increased as a result of this rulemaking.

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

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jared Larsen at DHWRules@dhw.idaho.gov or (208) 334-5500.

DATED this 5th day of November, 2025.

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

DOCKET NO. 16-0326-2501 - ADOPTION OF PENDING RULE

Substantive changes have been made in the pending rule.
Italicized red text **indicates amendments to the proposed text as adopted in the pending rule.**

The text of the proposed rule was published in the Idaho Administrative Bulletin,
Volume 25-6, June 4, 2025, pages 175 through 335.

This rule has been adopted as a pending rule by the Agency and is now awaiting review and final approval by the 2026 Idaho State Legislature.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE FOR DOCKET NO. 16-0326-2501

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

16.03.26 – MEDICAID PLAN BENEFITS

000. LEGAL AUTHORITY.
Sections 56-202(b), and 56-265, Idaho Code. ( )

(BREAK IN CONTINUITY OF SECTIONS)

003. BACKGROUND CHECK REQUIREMENTS.

01. Background Check Compliance. Background checks are required for specific providers under these rules. Providers who are required to have a background check and their contractors must comply with IDAPA 16.05.06. ( )

02. Variances. ( )

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

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

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

04. Providers Subject to Background Check Requirements. ( )

a. Adult Day Health Agencies. ( )

b. Behavior Consultation or Crisis Management Providers. ( )

c. Chore Services Providers. ( )

d. *Community Support Workers.* *( )*

e. Contracted Non-Emergency Medical Transportation (NEMT) Providers, with direct contact with participants except for Individual Contracted NEMT providers. ( )

f. Independent CHIS Providers. ( )

g. Non-Medical Transportation (NMT) Providers. ( )

h. Personal Assistance Agencies (PAA), including PAAs Acting as Fiscal Intermediaries. ( )

i. Provider types deemed by the Department to be at high risk for fraud, waste, or abuse. ( )

j. Respite Care Providers. ( )

k. Service Coordination Agencies. ( )

l. *Support Brokers.* *( )*

m. Supported Employment Agencies. ( )

004. (RESERVED)

005. DEFINITIONS: A THROUGH H.

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

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

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

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

05. Audit. An examination of provider records and financial records to determine compliance with Medicaid requirements and regulations or quality assurance. ( )

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

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

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

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

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

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

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

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

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

12. CMS. Centers for Medicare and Medicaid Services. ( )

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

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

15. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. ( )

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

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

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

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

***20.* Director**. The Director of the Department or their designee. ( )

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

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

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

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

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

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

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

28. **Facility**. Facility refers to a hospital, nursing facility (NF), or intermediate care facility for individuals with intellectual disabilities (ICF/IID). ( )

29. ***Family-Directed Community Supports (FDCS)****. A program option for children eligible for Children's HCBS State Plan Option.* ( )

30. ***Financial Management Services (FMS)****. Services provided by an FEA.* ( )

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

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

33. ***Home and Community Based Services (HCBS)****. Long-term services and supports that assist participants to remain in their home and community.* ( )

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

006. DEFINITIONS: I THROUGH O.

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

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

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

a. An RN; and ( )

b. A QIDP; and when required, a: ( )

i. Consultant physician; ( )

ii. Consultant social worker; or ( )

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. There is no other equally effective course of treatment available or suitable for the participant

requesting the service that is more conservative or substantially less costly; ( )

c. It meets any applicable Department criteria. Services that do not meet criteria require a PA; ( )

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

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

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

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

19. Minor Movable Equipment. Minor movable equipment as defined in Section 56-101(18), Idaho Code, with a unit cost under five thousand dollars ($5,000.) ( )

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

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

a. Participant's name; ( )

b. Description of item or service; ( )

c. Length of need, if applicable; ( )

d. Quantity, if applicable; ( )

e. Provider's name, National Provider Identification (NPI) and signature; and ( )

f. Date of signature. ( )

22. Ordinary. Costs incurred that are customary for normal operation of a business. ( )

23. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. ( )

007. DEFINITIONS: P THROUGH Z.

01. Participant. A person eligible for and enrolled in Medicaid. ( )

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

03. Personal Assistance Agency (PAA). An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for

personal assistants working for them, and is the employer of record as well as the actual employer. ( )

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

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

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

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

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

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

10. **Prosthetic Device**. Replacement, corrective, or supportive devices to: ( )

a. Artificially replace a missing portion of the body; ( )

b. Prevent or correct physical deformities or malfunctions; or ( )

c. Support a weak or deformed portion of the body. ( )

d. Computerized communication devices are not included in this definition. ( )

11. **Provider**. Any individual acting under Section 020 including, but not limited to certified registered nurse anesthetists, nurse practitioners, nurse midwives, clinical nurse specialists, pharmacists, physician assistants, and physicians. Alternatively, a partnership, association, corporation, or organization that furnishes medical goods or services in compliance with these rules. ( )

12. **Provider Status Review**. Written documentation identifying a participant's progress toward goals defined in their service plan. ( )

13. **Qualified Intellectual Disabilities Professional (QIDP)**. As described in 42 CFR 483.430(a). ( )

14. **Quality Improvement Organization (QIO)**. An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. ( )

15. **Recoupment**. As detailed in IDAPA 16.05.07. ( )

16. **Recreational Services**. Activities *and goods* that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties. *( )*

17. ***Readiness Review****. A review conducted by the Department to ensure that each FEA is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules.* *( )*

18. **Referral**. A documented recommendation from a healthcare professional to see another Medicaid

provider for a specific service. ( )

19. **Related Entity**. An organization associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. ( )

20. **Restrictive Intervention**. Any intervention used to restrict rights or freedom of movement and includes chemical, mechanical, *and* physical restraints, *or* seclusion. *( )*

21. **Retrospective Review**. A review of an item or service after it has been provided. The review determines medical necessity and conformity to Medicaid requirements. Claims that have already received payment may be subject to recoupment. ( )

22. **Rural Hospital-Based Behavioral Care Unit**. A Rural Hospital-Based Provider that qualifies as a behavioral care unit. ( )

23. **Service Coordination**. Case management activity to assist participants with gaining and coordinating access to necessary care and services appropriate to their needs. ( )

24. **Service Plan**. An initial or annual plan that identifies all services and supports based on a person-centered planning process and authorized by the Department. ( )

25. **Skilled Nursing Care**. Level of care for patients requiring twenty-four (24) hour skilled nursing services. ( )

26. **Supervision**. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. ( )

27. ***Support and Spending Plan (SSP)****. A document that functions as a participant's plan of care when the participant is eligible for and has chosen a CDCS option. This document identifies the goods, services, and supports selected by a participant, including those available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each one. The participant uses this document to manage their individualized budget.* *( )*

28. ***Support Broker (SB)****. An individual who advocates on behalf of the participant and who is hired by the participant to provide SB services.* *( )*

29. **Supports**. Services provided *for* a participant, or *a person who provides a support service. A support service may be a paid service provided by a CSW, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer*. *( )*

30. **Third Party**. Includes a person, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant. ( )

31. ***Traditional Adult DD Waiver Services****. A program option for participants eligible for the Adult DD Waiver consisting of specific Medicaid Enhanced Plan Benefits.* *( )*

32. ***Traditional Children's HCBS State Plan Option Services****. A program option for children eligible for the Children's HCBS State Plan Option consisting of specific Medicaid Enhanced Plan Benefits.* *( )*

33. **Utilization Control (UC)**. Program of prepayment screening and annual review by the Department determining the appropriateness of and the need for continued medical entitlement of applicants or participants in a NF. ( )

34. **Utilization Control Team (UCT)**. Team of Regional nurse reviewers that conducts on-site reviews of the care and services in NFs approved by the Department as Medicaid providers. ( )

35. Vocational Services. Services directly related to the preparation for paid or unpaid employment. Vocational services are provided with the expectation a participant will participate in a *work services program* or the general workforce within a year. ( )

(BREAK IN CONTINUITY OF SECTIONS)

025. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medically necessary services when a complete and properly submitted claim for payment has been received and each of the following conditions are met: ( )

a. The participant received services no earlier than the third month before an application was made on the participant's behalf; ( )

b. The provider verified the participant's eligibility on the date of service and can provide proof of the eligibility verification; ( )

c. Services provided after the participant's date of death cannot be reimbursed; and ( )

d. Not more than twelve (12) months have elapsed since the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. When a participant is determined retroactively eligible, the Department will reimburse providers for services within the period of retroactive eligibility, if a claim is submitted within twelve (12) months of the participant's eligibility determination. ( )

02. Comply With All Applicable Regulations. ( )

03. Comply With the Idaho Medicaid Provider Handbook. ( )

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

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

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

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

08. Prior Authorization (PA). The Department may require a PA for any service. Unless otherwise specified: ( )

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

030. GENERAL PAYMENT PROCEDURES.

01. Provided Services. ( )

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

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

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

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

02. Provider Reimbursement. ( )

a. The Department will pay the provider the lowest of: ( )

i. The provider's actual charge for service; or ( )

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

iii. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. ( )

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

i. Historical cost or regional reimbursement data. ( )

ii. Percent of charge. ( )

iii. A copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer or wholesaler. Reimbursement will be seventy-five percent (75%) of MSRP or quote. If the pricing

documentation is an invoice for items, reimbursement will be at cost plus ten percent (10%), plus shipping. ( )

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

v. HCBS are priced in accordance with approved service criteria. ( )

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

04. Other Noninstitutional Services. The Department will reimburse for noninstitutional services unless otherwise specified. ( )

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

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

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

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

07. Procedures for Medicare Cross-Over Claims. ( )

a. If a Medicaid participant is eligible for Medicare, the provider must first bill Medicare for the services before billing the Department. ( )

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

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

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

e. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. ( )

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

(BREAK IN CONTINUITY OF SECTIONS)

050. NF AND ICF/IID REIMBURSEMENT.

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

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

a. Reasonable costs account for both direct and indirect costs of provider services, including normal standby costs. ( )

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

c. The expectation of reasonable actual operating costs is that providers seek to minimize costs and that actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. ( )

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

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

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

04. Application of Related Party Transactions. ( )

a. Charges to a provider from related organizations may not exceed the billing to a related organization for these services. ( )

b. All home office costs unrelated to patient care are not allowable. ( )

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

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

i. When services are performed without pay, no cost may be reported. ( )

ii. Time records documenting actual hours worked are required for compensation to allow for reimbursement. ( )

iii. Compensation for undocumented work hours is not reimbursable. ( )

b. Related persons are defined as these relationships with a provider: ( )

i. Spouse; ( )

ii. Child or a descendant of a child; ( )

iii. Siblings, stepsiblings, or descendant thereof; ( )

iv. Parent, stepparent, siblings thereof, and their ancestors; ( )

v. Related by marriage; ( )

vi. Any other person without an arm's length relationship. ( )

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

a. *A*llowable compensation for providing administrative services is determined by: *( )*

i. *A*ll licensed beds in *every* facility administrative services *are provided.* *( )*

ii. *M*ore than fifty (50) beds *being restricted to an* upper limit for compensation *based on bed count*. *( )*

iii. *L*ess than fifty-one (51) beds *being* reimbursed at *an allowable* hourly rate. *Non*-administrative services are allowable at the reasonable market rate. *H*ours for each service type is documented. In no event will the total compensation for administrative and non-administrative duties exceed the limit applicable *for* the same *amount for* providing administrative services to facilities with fifty-one (51) *or more* beds. *( )*

b. Compensation for persons related to an owner is evaluated in the same manner as for an owner. ( )

c. When an owner provides services to more than one facility, compensation is distributed on the same basis as costs allocated for non-owners. ( )

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

07. Filing Dates. ( )

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

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

08. Failure to File. Late reports result in reductions to the interim rate. Failure to file required cost reports, including required supplemental information, unless a waiver is granted, results in a reduction of ten percent (10%) of the provider's rate(s) the first day of the month following a deadline date. Continued failure to comply results in complete payment suspension on the first day of the following month. When suspension or reduction occurs and a provider filed the required cost reports, amounts accruing to the provider during a suspension or reduction

period are restored. Loss of license or certification results in immediate termination of reimbursement, full scope audit, and settlement for the cost period. ( )

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

10. Audits. ( )

a. All financial reports are subject to audit to: ( )

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

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

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

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

v. Ensure policies and practices sufficiently meet fiduciary responsibilities for patients, funds, and property. ( )

vi. Effect final settlement when required. ( )

b. Normally, all annual statements are audited within the following year. ( )

c. Other statements and some annual audit recommendations are subject to limited scope audits evaluating provider compliance. ( )

d. Additional audits are required for: ( )

i. Significant changes of ownership. ( )

ii. Changes in management. ( )

iii. When an overpayment of twenty-five percent (25%) or more resulted in a completed cost period. ( )

e. Annual field audits are by appointment. Auditors identify themselves with a letter of authorization or Department I.D. cards. ( )

11. Audit Standards and Requirements. ( )

a. Before making any program payments to a prospective provider, the intermediary reviews a provider's accounting system and its capability of generating accurate statistical cost data. When a provider's record keeping capability fails to meet program requirements, the intermediary offers limited consultative services or suggests revisions of a provider's system to enable compliance. ( )

b. Examination of records and documents includes: ( )

i. Corporate charters or other ownership documents including those for parent or related companies and attachments describing property. ( )

ii. Minutes and memos of governing bodies, including committees and its agents. ( )

iii. All contracts. ( )

iv. Tax returns and records, including workpapers and other supporting documentation. ( )

v. All insurance contracts and policies including riders and attachments. ( )

vi. Leases. ( )

vii. Fixed asset records (see Capitalization of Assets). ( )

viii. Schedules of patient charges. ( )

ix. Notes, bonds, and other evidence of liabilities. ( )

x. Capital expenditure records. ( )

xi. Bank statements, canceled checks, deposit slips, and bank reconciliations. ( )

xii. Evidence of litigations involving a facility or its owners. ( )

xiii. All invoices, statements, and claims. ( )

xiv. Financial audit work papers prepared by any accounting firm a provider engages with are considered the provider's property and must be available to the intermediary upon request, under PRM, Subparagraph 2404.4(Q). ( )

xv. Ledgers, journals, all working papers, subsidiary ledgers, records, and documents relating to financial operation. ( )

xvi. All patient records, including trust funds and property. ( )

xvii. Time studies and other cost determining information. ( )

xviii. All other sources of information needed to form an audit opinion. ( )

c. Adequate cost information developed by a provider must be current, accurate, and sufficient detail to support payments made for services rendered. This includes all ledgers, books, records, and original cost evidence including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, timecards, payrolls, bases for apportioning costs, and other documentation pertaining to determination of reasonable cost, capable of being audited under PRM, Section 2304. ( )

d. Adequate expense documentation includes invoices or statements with invoices attached supporting the statement and must include: ( )

i. Service or sale date; ( )

ii. Terms and discounts; ( )

iii. Quantity; ( )

iv. Price; ( )

v. Vendor name and address; ( )

vi. Delivery address if applicable; ( )

vii. Contract or agreement references; and ( )

viii. Description including quantities, sizes, specifications, and brand names of services performed. ( )

e. Minor movable equipment is not capitalized. The cost of fixed assets and major movable equipment is capitalized and depreciated over the estimated useful life of an asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. ( )

f. Completed depreciation records must include the following for each asset: ( )

i. Description of the asset including serial number, make, model, accessories, and location. ( )

ii. Cost basis supported by invoices for purchase, installation, etc. ( )

iii. Estimated useful life. ( )

iv. Depreciation method (straight line, double declining balance, etc.). ( )

v. Salvage value. ( )

vi. Method of recording depreciation consistent with GAAP. ( )

vii. Additional information, such as additional first year depreciation, even when not an allowable expense. ( )

viii. Reported depreciation expense for the year and accumulated depreciation tied to the asset ledger. ( )

g. Depreciation methods are always acceptable. Methods of accelerated depreciation are only acceptable upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. ( )

h. An asset's depreciable life may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, Guidelines. Deviation from these guidelines is allowable only upon Department authorization. ( )

i. Lease purchase agreements are generally recognized by any the following characteristics: ( )

i. Lessee assumes normal ownership costs, such as taxes, maintenance, etc.; ( )

ii. Intent to create security interest; ( )

iii. Lessee acquires title by exercising a purchase option that requires little or no additional payment or, additional payments substantially less than the fair market value at purchase date; ( )

iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and ( )

v. Initial loan term significantly less than the useful life and lessee has the option to renew at a rental price substantially less than fair rental value. ( )

j. Assets acquired under such agreements are viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes, and maintenance are allowable. Rental or lease payments are not reimbursable. ( )

k. Complete personnel records including: ( )

i. Employment applications. ( )

ii. W-4 Forms. ( )

iii. Authorizations for any deductions such as insurance, credit union, etc. ( )

iv. Routine evaluations. ( )

v. Pay raise authorizations. ( )

vi. Statements of understanding of policies, procedures, etc. ( )

vii. Fidelity bond applications (when applicable). ( )

l. A system of internal control intended to provide a method of handling all routine and nonroutine tasks related to: ( )

i. Safeguarding assets and resources against waste, fraud, and inefficiency. ( )

ii. Promoting accuracy and reliability in financial records. ( )

iii. Encouraging and measuring compliance with company policy and legal requirements. ( )

iv. Determining the degree of efficiency related to various aspects of operations. ( )

m. An adequate system of internal control over cash disbursements including: ( )

i. Payment on invoices only, or statements supported by invoices. ( )

ii. Authorizations for purchase; a purchase order. ( )

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. ( )

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. ( )

v. Check of invoice accuracy. ( )

vi. Invoice approval policy. ( )

vii. Method of invoice cancellation to prevent duplicating payment. ( )

viii. Adequate separation of duties between ordering, recording, and paying. ( )

ix. System separation of duties between ordering, recording, and paying. ( )

x. Signature policy. ( )

xi. Pre-numbered checks. ( )

xii. Statement of policy regarding cash or check expenditures. ( )

xiii. Adequate internal control over recording transactions in the books of record. ( )

xiv. An imprest system for petty cash. ( )

n. Sound accounting practices including: ( )

i. Documentation of accounting policies and procedures, including capitalization, depreciation, and expenditure classification criteria. ( )

ii. Chart of accounts. ( )

iii. Budget or operating plans. ( )

12. Patient Funds. The safekeeping of Medicaid patient funds is the responsibility of the provider. Administration of these funds requires scrupulous care when recording all patient transactions. ( )

a. Funds provided for a patient's personal needs are used at the patient's discretion. Providers agree to manage these funds and render an accounting of funds but may not use them in any way. ( )

b. Providers are subject to legal and financial liabilities for committing any of the following acts and any other acts contrary to federal regulations: ( )

i. Management fees are not charged to manage patient trust funds and constitute double payment as normally performed by a facility employee whose salary is included in reasonable cost reimbursement. ( )

ii. Nothing is to be deducted from these funds, unless deductions are authorized by the patient or their agent in writing. ( )

iii. Interest accruing to patient funds on deposit is the patient's property and part of their personal funds. Interest from these funds is not available to the provider for any use, including patient benefits. ( )

c. Fund Management. Proper management includes the following at a minimum: ( )

i. Savings accounts, maintained separately from facility funds. ( )

ii. An accurate system of supporting receipts and disbursements to patients. ( )

iii. Written authorization for all deductions. ( )

iv. Signature verification. ( )

v. Deposit of all receipts on the same day received. ( )

vi. Minimal funds kept in a facility. ( )

vii. All funds must always be locked. ( )

viii. Policy statement regarding patient's funds and property. ( )

ix. Periodic review of all policies with staff in training sessions and with all new employees upon employment. ( )

x. System of periodic review and correction of policies and financial records for patient property and funds. ( )

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Service Categories Not Covered. The following service categories are not covered for payment by Medicaid *except as otherwise specified*: ( )

a. Acupuncture services; ( )

b. Naturopathic services; ( )

c. Bio-feedback therapy; ( )

d. Group hydrotherapy; ( )

e. Fertility-related services, including testing; ( )

f. Vocational services except for supported employment services; ( )

g. Educational services; ( )

h. Recreational services; ( )

i. Duplicative services; ( )

j. Housing except when approved for a medical institution; and ( )

k. Food, except when medically necessary or the home-delivered meals benefit. ( )

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

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

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

c. Laetrile therapy; ( )

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

e. Drugs supplied to patients for self-administration other than those allowed under these rules; ( )

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

g. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service; ( )

h. Surgical procedures on the cornea for myopia; or ( )

i. Services as detailed in Section 56-273, Idaho Code. ( )

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

a. The treatment or procedure is in Phase I clinical trials; ( )

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

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

(BREAK IN CONTINUITY OF SECTIONS)

102. CASE MANAGEMENT: COVERAGE AND LIMITATIONS.

01. Home Visiting Coverage. ( )

a. Assessment for medical, educational, social, or other service needs; ( )

b. Development and revision of a plan to address goals; ( )

c. Referral and related activities for necessary services; and ( )

d. Monitoring of progress. ( )

e. Services do not include case management integral to another covered service or that constitutes direct delivery of referred services. ( )

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

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

(BREAK IN CONTINUITY OF SECTIONS)

182. CHIS: COVERAGE AND LIMITATIONS.

01. Service Delivery. CHIS may be delivered in the community, the participant's home, or in a DDA. Duplication of services is not reimbursable. ( )

02. Required Order. CHIS must be ordered by a provider within their scope of practice. ( )

a. CHIS providers cannot seek reimbursement for services provided more than thirty (30) calendar days prior to the signed and dated order. ( )

b. The order is only required to be completed once and must be received prior to submitting the initial PA request. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days, a new order is required. ( )

03. Required Screening. Needs are determined through the current version of the Department-approved screening tools. The tool is only required to be completed once and must be completed prior to submitting the initial PA request. New screenings are required for participants who have not accessed CHIS for more than three hundred sixty-five (365) calendar days. ( )

04. Services. All CHIS ordered on a participant's ACTP must be prior authorized by the Department. Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) participants. As the number and needs of the participants increase, the participant ratio in the group must be adjusted from three (3) to two (2). Group services will only be reimbursed when the participant's objectives relate to benefiting from group interaction. The following CHIS are reimbursable services when provided under these rules: ( )

a. Habilitative Skill Building utilizes direct intervention techniques to develop, improve, and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a participant. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Services include individual or group interventions. ( )

b. Behavioral Intervention utilizes direct intervention techniques to produce positive meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies while also addressing any identified habilitative skill building needs or interfering behaviors. Intervention services may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the participant. Services include individual or group interventions. ( )

c. Interdisciplinary Training is a companion service to behavioral intervention and habilitative skill building and assists with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is for collaboration, with the participant present, during the provision of services between the intervention specialist or professional and a provider. ( )

d. Crisis Intervention includes providing training to staff directly involved with the participant, delivering intervention directly with the eligible participant, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. Crisis intervention is provided in the home or community on a short-term basis not to exceed thirty (30) days. Positive behavior interventions must be used prior to, and in conjunction with, the implementation of any restrictive intervention. Crisis intervention is available for participants who have an unanticipated event, circumstance, or life situation that places a participant at risk of at least one (1) of the following: ( )

i. Hospitalization; ( )

ii. Out-of-home placement; ( )

iii. Incarceration; or ( )

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. ( )

e. The ACTP must contain the following: ( )

i. Clinical interviews must be completed with the parent or legal guardian; ( )

ii. Objective and validated comprehensive skills or developmental assessment. The most current assessment must be used and be from within the last year; ( )

iii. Review of assessments, reports, and relevant history; ( )

iv. Observations in at least one (1) environment; ( )

v. Clinical summary and *orders*; *( )*

vi. A transition plan; and ( )

vii. Be signed by the individual completing the assessment and the parent or legal guardian. ( )

f. Case Management is available to assist participants accessing CHIS by the Department as described in the Medicaid Provider Handbook. ( )

(BREAK IN CONTINUITY OF SECTIONS)

184. CHIS: PROVIDER QUALIFICATIONS AND DUTIES.
CHIS are delivered by individuals who meet one (1) of the qualifying criteria below and are employed by a DDA, or who meet the criteria for enrolling as an independent CHIS provider. ( )

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Obtain an independent Medicaid provider agreement through the Department and maintain in good standing; ( )

b. Be certified in CPR and first aid prior to delivering services and maintain current certification thereafter; ( )

c. Follow all applicable requirements in the CHIS sections; and ( )

d. Not receive supervision from an individual that they are directly supervising. ( )

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

10. Intervention Specialists. Individuals acting as an intervention specialist or professional and who provide services to children birth to three (3) years of age must also demonstrate a minimum of two hundred forty

(240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. ( )

a. An elementary education certificate or special education certificate with an endorsement in early childhood special education; or ( )

b. A blended Early Childhood or Early Childhood Special Education (EC or ECSE) certificate; or ( )

c. This individual must have a minimum of twenty-four (24) semester credits from an accredited college or university, which can be within their bachelor's or master's degree coursework or can be in addition to the degree coursework. Courses must cover the following: ( )

i. Promotion of development and learning for children from birth to five (5) years of age. ( )

ii. Assessment and observation methods that are developmentally appropriate assessment of young children with developmental delays or disabilities; ( )

iii. Building family and community relationships to support early interventions; ( )

iv. Development of appropriate curriculum for young children; ( )

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children and their families; and ( )

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. ( )

(BREAK IN CONTINUITY OF SECTIONS)

191. PREVENTIVE HEALTH ASSISTANCE (PHA): PARTICIPANT ELIGIBILITY.

01. Behavioral PHA. The participant must have their PCP determine eligibility for Behavioral PHA. The participant qualifies by meeting one (1) of the following: ( )

a. For an adult, a body mass index (BMI) of thirty (30) or higher or eighteen and one-half (18 1/2) or lower. ( )

b. For a child, a body mass index (BMI) that falls in either the overweight or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. ( )

02. Wellness PHA. A participant who is required to pay premiums for eligibility under *state children's health insurance program (*SCHIP*.)* ( )

(BREAK IN CONTINUITY OF SECTIONS)

205. LABORATORY AND RADIOLOGY SERVICES: PROVIDER REIMBURSEMENT.

01. Provider of Service. Payment for laboratory tests can only be made to the actual provider of that service, except in the case of: ( )

a. An independent laboratory that can bill for a reference laboratory; ( )

b. A transplant facility that can bill for histocompatibility testing; and ( )

c. Healthcare professionals acting within the licensure and scope of their practice. ( )

02. Specimen Collection Fee. Collection fees for specimens drawn by venipuncture or catheterization are payable only to the provider or laboratory who draws the specimen. If done during an office visit on the same day the service is ordered, specimen collection is reimbursable even if PA is not approved. ( )

(BREAK IN CONTINUITY OF SECTIONS)

212. PRESCRIPTION DRUGS: COVERAGE AND LIMITATIONS.

01. General Drug Coverage. Medicaid covers prescription drugs not excluded under this rule that are legally obtainable by the order of a prescriber under Section 54-1705*A*, Idaho Code. ( )

02. Preferred Drug List (PDL). ( )

a. The PDL identifies preferred drugs and non-preferred drugs within a therapeutic class designated by the Department and reviewed by the Pharmacy and Therapeutics Committee (P&T Committee). ( )

b. A brand name drug may be designated as a preferred drug by the Department if the net cost of the brand name drug after consideration of all rebates is less than the cost of the generic equivalent. ( )

c. The Director makes final decisions regarding the designated preferred or non-preferred status of drugs based on therapeutic recommendations from the P&T Committee and cost analysis from the Medicaid Pharmacy Program. ( )

03. Covered Drug Products. Medicaid provides coverage to participants for the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the SSA: ( )

a. Agents, when used to promote smoking cessation. ( )

b. Prescription vitamins and mineral products. Covered agents include the following: ( )

i. Injectable vitamin B12 (cyanocobalamin and analogues); ( )

ii. Vitamin K and analogues; ( )

iii. Prescription vitamin D and analogues; ( )

iv. Prescription pediatric vitamins, minerals, and fluoride preparations; ( )

v. Prenatal vitamins for pregnant or lactating individuals; and ( )

vi. Prescription folic acid and oral prescription drugs containing folic acid in combination with vitamin B12 or iron salts, or both, without additional ingredients. ( )

c. Certain prescribed non-prescription products, including the following: ( )

i. Permethrin; ( )

ii. Oral iron salts; ( )

iii. Disposable insulin syringes and needles; and ( )

iv. Insulin. ( )

d. Barbiturates. ( )

e. Benzodiazepines. ( )

04. Additional Criteria for Coverage. The Director, acting upon the recommendation of the P&T Committee, may determine a non-prescription drug product is covered that is therapeutically interchangeable with prescription drugs in the same pharmacological class following evidence-based comparisons of efficacy, effectiveness, clinical outcomes, and safety, and the product is deemed to be a cost-effective alternative. ( )

05. Excluded Drug Products. Medicaid excludes from coverage the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the SSA: ( )

a. Agents, when used for the symptomatic relief of cough and colds. ( )

b. Agents, when used for the treatment of obesity. ( )

c. Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. ( )

d. Agents, when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration (FDA). ( )

06. Additional Excluded Drugs. Drugs are not covered when ineligible for federal financial participation. ( )

07. Limitation of Quantities. Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month because of a single prescription except: ( )

a. Providers may be reimbursed for up to a three (3) month supply of select medications or classes of medications for a participant who has received the same dose of the same select medication or class of medications for two (2) months or longer. The Director, acting upon the recommendation of the P&T Committee, approves the list of covered maintenance medications, which targets medications that are administered continuously rather than intermittently, are used most commonly to treat a chronic disease state, and have a low probability for dosage changes. The list of covered maintenance medications is available on the Medicaid Pharmacy website at http://medicaidpharmacy.idaho.gov. ( )

b. Contraceptive products may be dispensed in a quantity sufficient for up to six (6) months. ( )

(BREAK IN CONTINUITY OF SECTIONS)

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

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

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

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

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

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

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

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

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

323. SBS: COVERAGE AND LIMITATIONS.
The Department will pay for services including medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. ( )

01. Excluded Services. ( )

a. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. ( )

b. Services provided more than thirty (30) days prior to the signed and dated recommendation or referral. ( )

02. Evaluation and Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: ( )

a. Be conducted by providers for the respective SBS discipline; ( )

b. Be directed toward a diagnosis; ( )

c. Include recommended interventions to address each need; and ( )

d. Include name, title, and signature of the person conducting the evaluation. ( )

03. Reimbursable Services. Providers can bill for the following health-related services provided under the recommendation of a provider for reimbursement. The recommendations or referrals are valid up to three hundred sixty-five (365) days. ( )

a. Behavioral Intervention is a direct intervention used to promote positive, meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies, while also addressing any identified habilitative skill building needs and the student's ability to participate in educational services through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. Behavioral intervention includes conducting a functional behavior assessment and developing a behavior implementation plan for preventing or treating behavioral conditions. This service is provided to students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. ( )

i. Group services provided by one (1) qualified staff providing direct services for two (2) or three (3) students. ( )

ii. As the severity of the students with behavioral issues increases, the student ratio in the group must be adjusted from three (3) to two (2). ( )

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. ( )

b. Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members. ( )

i. Behavioral consultation cannot be provided as a direct intervention service. ( )

ii. Behavioral consultation must be limited to thirty-six (36) hours per year. ( )

c. Crisis intervention as defined for CHIS services. This service is provided on a short-term basis, typically not exceeding thirty (30) school days. ( )

d. Habilitative skill building as defined for CHIS services. ( )

e. Interdisciplinary training as defined for CHIS services. ( )

f. Durable Medical Equipment and Supplies for use at the school where the service is provided. The equipment and supplies must be for the student's exclusive use. All equipment purchased by Medicaid belongs to the student. ( )

g. Nursing services including emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. ( )

h. Occupational Therapy. ( )

i. PCS include medically oriented tasks having to do with the student's physical or functional requirements. PCS do not require a goal on the plan of service. The provider must deliver at least one (1) of the

following services: ( )

i. Basic personal care and grooming to include bathing, hair care, assistance with clothing, and basic skin care; ( )

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with bathroom routines; ( )

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; ( )

iv. Assisting the student with provider-ordered medications that are ordinarily self-administered, under IDAPA 24.34.01; ( )

v. Non-nasogastric gastrostomy tube feedings meeting the requirements under personal care services. ( )

j. Physical Therapy. ( )

k. Psychological Evaluation. ( )

l. Psychotherapy. ( )

m. Skills Building/Community-Based Rehabilitation Services (CBRS) are interventions to reduce the student's disability by assisting in gaining and utilizing skills necessary to participate in school. They are designed to build competency and confidence while increasing mental health and/or decreasing behavioral symptoms. Skills Building/CBRS provides training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, and coping skills to prevent placement in a more restrictive situation. ( )

n. Speech/Audiological Therapy and Evaluation. ( )

o. Social History and Evaluation. ( )

p. Transportation Services. Providers can receive reimbursement for mileage for transporting a student between home and school when: ( )

i. The student requires special transportation assistance, a wheelchair lift or an attendant, when medically necessary; ( )

ii. The vehicle is specifically adapted to meet the needs of a disability; ( )

iii. The student receives Medicaid-reimbursable services billed by the provider, other than transportation, on the day transportation is provided; ( )

iv. The transportation is included on the student's plan; and ( )

v. The mileage, as well as the services performed by the attendant, are documented. ( )

q. Interpretive services for a student requiring an interpreter to communicate with the professional or paraprofessional providing a health-related service may be billed when services are: ( )

i. Limited to the specific time the health-related service is received. Documentation must include the service provided. ( )

ii. Included on the student's plan; and ( )

iii. Provided by a professional or paraprofessional unable to communicate in the student's primary language. ( )

(BREAK IN CONTINUITY OF SECTIONS)

325. SBS: PROVIDER QUALIFICATIONS AND DUTIES.
Qualifications for covered services include licensure and acting within the scope of practice, where applicable. ( )

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

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

i. Be at least eighteen (18) years of age; ( )

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; ( )

iii. Meet the paraprofessional requirements under IDAPA 08.02.02. ( )

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

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

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

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

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

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

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

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

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

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

f. Evidence Based Model (EBM) Intervention Specialist. As defined for CHIS services. ( )

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

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

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

b. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, excluding an RN or audiologist; ( )

c. An occupational therapist; ( )

d. An intervention professional; or ( )

e. An EBM intervention professional. ( )

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

a. An intervention paraprofessional; ( )

b. An intervention technician; ( )

c. An intervention specialist; ( )

d. An intervention professional; ( )

e. An EBM intervention paraprofessional; ( )

f. An EBM intervention specialist; ( )

g. An EBM intervention professional; ( )

h. A licensed physician, licensed practitioner of the healing arts; ( )

i. An advanced practice registered nurse; ( )

j. A licensed psychologist; ( )

k. A licensed clinical professional counselor or professional counselor; ( )

l. A licensed marriage and family therapist; ( )

m. A licensed Masters social worker, licensed clinical social worker, or licensed social worker; ( )

n. A psychologist extender; ( )

o. An RN; ( )

p. A licensed occupational therapist; or ( )

q. An endorsed or certified school psychologist. ( )

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

a. An intervention paraprofessional; ( )

b. An EBM intervention paraprofessional; ( )

c. An EBM intervention specialist; or ( )

d. An EBM intervention professional. ( )

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

a. An intervention specialist; ( )

b. An intervention professional; ( )

c. An EBM intervention specialist; ( )

d. An EBM intervention professional. ( )

06. Medical Equipment and Supplies. ( )

07. Nursing Services. ( )

08. Occupational Therapy and Evaluation. Therapy rules apply. ( )

09. Personal Care Services (PCS). Must be provided by or under the direction of an RN. ( )

a. Providers of PCS must have at least one (1) of the following qualifications: ( )

i. Licensed Registered Nurse (RN). ( )

ii. Licensed Practical Nurse (LPN). ( )

iii. Certified Nursing Assistant (CNA). ( )

iv. Personal Assistant. A person with training to ensure the quality of services who is at least eighteen (18) years of age. ( )

b. The RN must review or complete, or both, the PCS assessment and develop or review, or both, the written plan of care annually. Oversight provided by the RN must include all of the following: ( )

i. Development of the written PCS plan of care; ( )

ii. Review of the treatment given by the personal assistant through a review of the student's PCS service detail reports as maintained by the provider; and ( )

iii. Reevaluation of the plan of care as necessary, but at least annually. ( )

c. The RN must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. ( )

10. Physical Therapy and Evaluation. Therapy rules apply. ( )

11. Psychological Evaluation. ( )

12. Psychotherapy. ( )

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

a. Licensed physician, licensed practitioner of the healing arts; ( )

b. Advanced practice registered nurse; ( )

c. Licensed psychologist; ( )

d. Licensed clinical professional counselor or professional counselor; ( )

e. Licensed marriage and family therapist; ( )

f. Licensed master's social worker, licensed clinical social worker, or licensed social worker; ( )

g. Psychologist extender registered with the Division of Occupational and professional Licenses; ( )

h. Licensed registered nurse (RN); ( )

i. Licensed occupational therapist; ( )

j. Endorsed or certified school psychologist; ( )

k. Skills Building/Community Based Rehabilitation Services specialist who must: ( )

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

ii. Have a credential required for CBRS specialists. ( )

14. Speech/Audiological Therapy. Therapy rules apply. ( )

15. Social History and Evaluation. ( )

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

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

(BREAK IN CONTINUITY OF SECTIONS)

471. NF: ELIGIBILITY.
The Department determines whether a participant meets criteria for NF services, any patient liability and whether a participant's needs can be met in alternative living situations other than residing in a NF. The participant can select any certified NF to provide the level of care (LOC) required, if approved. ( )

01. Determination. The Department determines a participant's level of care requirement and any need for DD or mental illness (MI) active treatment during the Level II screen. ( )

a. Adult LOC. The Department uses a standard assessment to determine adults meet one (1) of the *PDPM* classifications. ( )

b. Children's LOC. A child meets LOC when the age-appropriate developmental milestones, risk factors, and aggregate care or intervention needs identified in assessments indicate one (1) or more of the following applies as documented by physician's orders, progress notes, a service plan, and nursing or therapy notes: ( )

i. A complex provider prescribed service that requires skills of an RN or licensed physical or occupational therapist or only under equivalent supervision for safe and effective delivery. ( )

ii. The child's condition requires skilled care to sustain current capacities, regardless of their restoration potential, even when improvement is not possible. ( )

02. Authorization. The Department does not authorize payment to any NF for care or services beyond the NF's licensed level of care or capability. The Department notifies the NF with the authorized payment for services and any patient liability prior to admission. ( )

(BREAK IN CONTINUITY OF SECTIONS)

530. HCBS.
Services and supports to assist eligible participants to remain in their home and community. Federal HCBS requirements and adherence to the person-centered service plan implementation apply to Medicaid providers, where applicable. HCBS includes: ( )

01. A&D Waiver Services. ( )

02. Consumer-Directed Services. ( )

03. DD *HCBS State Plan* and Waiver Services. ( )

04. PCS. ( )

05. Youth Empowerment Services (YES) for Children with Serious Emotional Disturbance (SED). ( )

531. HCBS EXCEPTIONS.
These rules do not supersede decision-making authority legally assigned on the participant's behalf including: ( )

01. Payees appointed by the SSA. ( )

02. Judicial Restrictions. Court-imposed restrictions due to probation, parole, or for commitments to the Department; and ( )

03. Legal Guardians. It is presumed that the parents of participants birth through seventeen (17) years of age have full decision-making authority unless a minor child has another legally assigned decision-making authority. ( )

(BREAK IN CONTINUITY OF SECTIONS)

540. A&D WAIVER SERVICES: DEFINITIONS.

01. A&D Waiver Services. Services for the elderly and physically disabled to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like or community-based setting. It does not include participants in skilled, or intermediate care facilities, nursing facilities, ICF/IID or hospitals. When possible, services should be available in the participant's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports. ( )

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

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

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

(BREAK IN CONTINUITY OF SECTIONS)

561. DD DETERMINATION STANDARDS: PARTICIPANT ELIGIBILITY.
Assessments required for determining eligibility are completed prior to the participant receiving services and include documentation of a DD, an MSDA, and a functional assessment. For adult DD waiver services, an assessor must determine the participant meets ICF/IID level of care. DD as under Section 66-402, Idaho Code, is a chronic disability that appears before the age of twenty-two (22) years evidenced by: ( )

01. Impairment. Impairment is attributed to one (1) of the following: ( )

a. Intellectual Disability. ( )

i. IQ test score of seventy (70) or below with a five (5) point standard error of measurement; or ( )

ii. A delay of thirty percent (30%) overall on a functional assessment when under the age of five (5). ( )

b. Cerebral Palsy. ( )

c. Epilepsy, except when seizure-free and not on medication for three (3) years. ( )

d. Autism. ( )

e. Other conditions closely related or similar to a-d. requiring similar treatment or services: ( )

i. IQ test score above seventy-five (75) when functional limitations create a condition like intellectual disability. ( )

ii. Disruption in motor function like cerebral palsy. ( )

iii. Disorder causing interruption of consciousness like epilepsy. ( )

iv. Not a mental illness. ( )

f. Dyslexia resulting from a-e. ( )

02. Substantial Functional Limitations. The impairment requires a combination and sequence of services that need to be individually planned and coordinated for substantial functional limitations within three (3) major life activities in b-h. ( )

a. Substantial functional limitations are demonstrated by having a score of two (2) standard deviations below the mean. Participants under three (3) years of age can alternatively by: ( )

i. Scoring thirty percent (30%) below age norm; or ( )

ii. Exhibiting a six (6) month delay. ( )

b. Self-care. ( )

i. Under Age twenty-one (21): Manifested when age-appropriate skills are limited, and substantial assistance is required. ( )

ii. Age twenty-one (21) and Over: Manifested when the person requires assistance in performing eating, hygiene, grooming, or health care skills, or the time to complete these tasks causes substantial impairment of conducting other ADL or retaining employment. ( )

c. Receptive and expressive language. ( )

i. Under Age three (3): Manifested when they have been diagnosed with performance thirty percent (30%) below age norm (adjusted for prematurity up to two (2) years) or demonstrated at least two (2) standard deviations below the mean in either area or one-and-one half (1 1/2) below in both areas of language development. ( )

ii. Age three (3) and Above: Manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). ( )

d. Learning manifested when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that interventions beyond normal are required for the development of social, self-care, language, academic, or vocational skills. ( )

e. Mobility. ( )

i. Under Age twenty-one (21): Measured by an age-appropriate instrument that compares the child's skills for postural control and movement and coordinated use of the small muscles with skills expected of children of the same age. ( )

ii. Age twenty-one (21) and Over: Manifested when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place.

( )

f. Self-direction. ( )

i. Under Age twenty-one (21): Manifested when the child is unable to help themselves or cooperate with others with age-appropriate assistance to meet personal needs, learn new skills, follow rules, and adapt to environments. ( )

ii. Age twenty-one (21) and Over: Manifested when assistance is required in managing personal finances, protecting self-interest, or making decisions that may affect well-being. ( )

g. Capacity for independent living. ( )

i. Under Age twenty-one (21): Measured by an age-appropriate instrument that compares personal independence and social responsibility expected of comparable age and cultural groups. ( )

ii. Age twenty-one (21) and Over: A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. ( )

h. Economic self-sufficiency. ( )

i. Under Age five (5): Evidenced by eligibility for SSI, early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA). ( )

ii. Age five (5) to Age Twenty-one (21): Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. ( )

iii. Age twenty-one (21) and Over: Manifested when unable to perform the tasks necessary for regular employment or limited in productive capacity to the extent that their earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. ( )

03. Necessity of Care. The need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of life-long or extended duration and individually planned and coordinated. ( )

a. Under Age five (5): Determined by a multi-disciplinary team for early intervention services through SSI, an IFSP, child study team or early childhood special education services through an IEP. ( )

b. Age five (5) and Over: Life-long or extended duration means the condition has reasonable likelihood of continuing for a protracted period, including continuation throughout life. ( )

(BREAK IN CONTINUITY OF SECTIONS)

606. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialists. Developmental Specialists for adults must have two hundred forty (240) hours of professionally supervised experience with individuals with DD and either: ( )

a. Possess a bachelor's or master's degree in *the human services field*; or *( )*

b. Possess a bachelor's or master's degree in any area and have: ( )

i. Completed a competency course approved by the Department relating to Developmental Specialist

job requirements; and ( )

ii. Passed a Department-approved competency examination. ( )

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, may continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. ( )

02. Developmental Therapy Paraprofessionals. Paraprofessionals who are at least seventeen (17) years old may be used by a DDA to provide developmental therapy when under the supervision of a Developmental Specialist. ( )

03. Collaboration with Other Providers. When participants receive rehabilitative or habilitative services from other providers, the DDA must coordinate each participant's program with their providers to maximize skill acquisition and generalization of skills across environments and avoid duplication of services. DDAs must maintain documentation of any collaboration that includes other service plans. Participant's files must also reflect how all services are integrated into a DDA's plan for each participant. ( )

(BREAK IN CONTINUITY OF SECTIONS)

661. – *799.* (RESERVED)

CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS) OPTION
(Sections 800-846)

800. PARTICIPANT ELIGIBILITY.

***01. Eligibility Determination**. In order to choose the CDCS option, the participant must first be determined Medicaid-eligible and determined to meet existing Adult DD waiver or Children's HCBS State Plan Option requirements.* ( )

***02. Participant Agreement**. The participant, if able, and their legal representative, if one exists, must agree in writing using a Department-approved form to the following:* ( )

***a.** Accept the following guiding principles for the CDCS option;* ( )

i. Freedom for the participant to make choices and plan their own life; ( )

ii. Authority for the participant to control resources allocated to them to acquire needed supports; ( )

iii. Opportunity for the participant to choose their own supports; ( )

iv. Responsibility for the participant to make choices and take responsibility for the result of those choices; and ( )

v. Shared responsibility between the participant and their community to help the participant become an involved and contributing member of that community. ( )

***b.** Agree to meet the participant responsibilities outlined in these rules;* ( )

***c.** Take responsibility for and accept potential risks, and any resulting consequences, for their support choices. If the participant is unable to give consent, this falls to their legal representative; and* ( )

***d.** Acknowledge and follow the applicable HCBS rules.* ( )

*03. **Involuntary Removal**. Participants involuntarily removed from the CDCS option will be ineligible for this option for a period of five (5) years. Re-application will be reviewed on a case-by-case basis and will include consideration of the previous conditions for removal. ( )*

801. PARTICIPANT RESPONSIBILITIES.
With the assistance of the SB, and the legal representative, if one exists, the participant is responsible for the following: ( )

*01. **Guiding Principles**. Accepting and honoring the guiding principles for the CDCS option defined in the participant agreement. ( )*

*02. **Person-Centered Planning**. Directing the person-centered planning process in order to identify and document paid and unpaid support and service needs, wants, and preferences. ( )*

*03. **Rates**. Negotiating payment rates for all paid community supports they want to purchase. They must also ensure rates negotiated for supports and services do not exceed the prevailing market rate, are cost-effective when comparing them to reasonable alternatives, and include the details in the employment agreements. ( )*

*04. **Agreements**. Completing and implementing agreements for the FEA, the SB, and CSWs, and submitting the agreements to the FEA. These agreements must be submitted on Department-approved forms and must specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. The participant is responsible for ensuring that each employment agreement; clearly identifies the qualifications needed to provide the support or services; includes a statement signed by the hired worker that they possess the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that; the participant is the employer even though payment comes from a third party; employees are under the direction and control of the participant; services must be delivered consistent with the HCBS rules and no employer related claims will be filed against the Department. ( )*

*05. **SSP**. Developing a comprehensive SSP, based on the information gathered during person-centered planning. ( )*

*06. **Time Sheets and Invoices**. Reviewing and verifying that goods and services being billed were provided and indicating that they approve of the bill by signing the timesheet or invoice. ( )*

*07. **Quality Assurance and Improvement**. Providing feedback to the best of their ability regarding their satisfaction with the goods and services they receive and the performance of their workers. ( )*

*08. **Sufficient Staffing**. Hiring enough CSWs to ensure services are rendered in a manner for the health and safety of the participant. ( )*

*09. **Required Classes**. The participant must attend classes on Guide Training by the Department and FEA Training. ( )*

802. CONTINUATION OF THE CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS) OPTION.
The following requirements must be met or the Department may require the participant to discontinue the CDCS option: ( )

*01. **Required Supports**. The participant is willing to work with an SB. ( )*

a. The participant can only change FEA services by providing a written request to their current FEA provider at least sixty (60) days in advance, and this change must occur at the end of a fiscal quarter. The request must include the name of the new FEA chosen by the participant and provide the specific date the change will occur. ( )

b. *When a participant provides a written request to their current FEA provider to change to a different FEA provider, the current FEA provider must notify the participant of the specific date that the last payroll run will occur at the end of the fiscal quarter.* ( )

02. SSP*. The participant's SSP is followed.* ( )

03. Risk and Safety Back-Up Plans*. Back-up plans to manage risks and safety are followed.* ( )

04. Health and Safety Choices*. The participant's choices do not directly endanger their health, welfare, and safety or endanger or harm others.* ( )

803. CIRCLE OF SUPPORTS.

01. Focus*. The participant's COS is built and operates with the primary goal of working in the interest of the participant. The group's role is to give and get support for the participant and to develop an SSP, along with and on behalf of the participant, to help the participant accomplish their personal goals.* ( )

02. Members*. A COS is unpaid, selected by the participant, and may include family members, friends, neighbors, co-workers, and other community members. For the SDCS, when the participant's legal guardian is selected as a CSW, the COS must include at least one (1) non-family member who is not the SB. For the purposes of this chapter a family member is anyone related by blood or marriage to the participant or legal guardian.* ( )

03. Selection and Duties*. Members are selected by the participant and commit to work within the group to:* ( )

a. *Promote and improve the life of the participant in accordance with the participant's choices and preferences; and* ( )

b. *Meet regularly to assist the participant to accomplish their expressed goals.* ( )

04. Natural Supports*. Natural supports may perform any duty of the SB as long as the SB still completes the required responsibilities listed in these rules. Additionally, any CSW task may be performed by a qualified natural support person. Supports provided by a natural support person must be identified on the participant's SSP, but time worked does not need to be recorded or reported to the FEA.* ( )

804. (RESERVED)

805. PAID CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS).
Participants must purchase FMS and SB services to participate in the CDCS option. Participants must purchase goods and community supports through an FEA who is providing the FMS. ( )

01. FMS*. The Department will enter into a provider agreement with qualified FEAs, as defined in these rules, to provide FMS for payroll and reporting functions to participants who choose the CDCS option.* ( )

02. SB Services*. Services provided by a qualified SB to assist in making informed choices, participate in a person-centered planning process, and become skilled at managing their own supports such as negotiating and budgeting. SBs have to apply for requalification annually.* ( )

03. CSW Services*. The CSWs provide identified supports to the participant. If the identified support requires specific licensing or certification within the state of Idaho, the identified CSW must obtain the applicable license or certification. Identified supports include activities that address the participant's preference in both FDCS and SDCS, unless otherwise specified, for:* ( )

a. *Job support for SDCS to help the participant secure and maintain employment or attain job advancement;* ( )

b. *Personal support to help the participant maintain health, safety, and basic quality of life;* ( )

c. Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community; ( )

d. Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors; ( )

e. Learning support for SDCS to help the participant learn new skills or improve existing skills that relate to their identified goals; ( )

f. Transportation support to help the participant accomplish their identified goals; and ( )

g. Skilled nursing support for SDCS identified in the participant's plan that is within the scope of the Nurse Practice Act and is provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. ( )

*04. **Medically Necessary Equipment**. Adaptive and therapeutic equipment is medically necessary, meets a medical or accessibility need, and promotes increased independence. FDCS may substitute medical necessity for minimizing the participant's need for institutionalization. Items may be covered when: ( )*

a. Not available through another source; ( )

b. Identified in the participant's plan; ( )

c. Safe and effective treatment that meets evidence – based treatment criteria; ( )

d. Optimal for the participant's health, safety and welfare; ( )

e. Least costly alternative that reasonably meets the identified need; ( )

f. For the sole benefit of the participant; and ( )

g. Meets at least one (1) of the following: ( )

i. Assist the ability of the participant to remain in the community; ( )

ii. Enhance community inclusion and family involvement; and ( )

iii. Decrease dependency on formal support services. ( )

*05. **Limitations**. Services have the following limitations: ( )*

a. CDCS Purchased items and services must meet needs related to a developmental disability diagnosis. The use of CDCS and FDCS purchased items by an individual other than the participant is prohibited. The following types of items or services are not covered: ( )

i. For the convenience of a caregiver; ( )

ii. Educational; ( )

iii. Recreational; or ( )

iv. Vocational except pre-vocational and job supports. ( )

b. CDCS services may only be rendered by (1) staff to one (1) participant at a time. Staff may not: ( )

i. Render any other support, service, or supervision, paid or unpaid, to any other individual; or ( )

ii. Perform multiple services concurrently. ( )

c. *CDCS and FDCS transportation support is limited to one thousand eight hundred (1,800) miles annually, unless otherwise authorized. ( )*

806. UNPAID COMMUNITY SUPPORTS AND SERVICES.
The Department requires that participants and their SB identify and prioritize the use of any goods, services and supports available outside of Medicaid-funded services that can be provided by an unpaid natural support such as a family member, a friend, a neighbor or other volunteer. ( )

807. – 809. (RESERVED)

810. SUPPORT BROKER (SB) REQUIREMENTS AND LIMITATIONS.

01. SB Requirements*. Individuals interested in becoming an SB must: ( )*

a. *Be eighteen (18) years of age or older; ( )*

b. *Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field; and ( )*

c. *Have at least two (2) years verifiable experience with the target population and ( )*

d. *Knowledge of services and resources in the developmental disabilities field. ( )*

02. Application Exam*. Applicants that meet the minimum requirements under this rule will receive training materials and resources to prepare for the application exam. Under FDCS, children's SBs must attend an initial training. Applicants must earn a score of seventy percent (70%) or higher to pass. Applicants may take the exam up to three (3) times. After the third time, the applicant will not be allowed to retest for twelve (12) months from the date of the last exam. Applicants who pass the exam, and meet all other requirements under these rules, will be eligible to enter into a Medicaid Support Broker Agreement with the Department. ( )*

03. Required Ongoing Training*. All SBs must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of SB services. Up to six (6) hours may be obtained through independent self-study. The remaining hours must consist of classroom training. ( )*

04. Termination*. The Department may terminate the Medicaid Support Broker Agreement in accordance with Section 56-209h(6), Idaho Code, or when the SB: ( )*

a. *Is no longer able to pass a background check under these rules. ( )*

b. *Puts the health or safety of the participant at risk by failing to perform job duties under the employment agreement. ( )*

c. *Does not receive and document the required ongoing training and requalification. ( )*

05. Limitations*. The SB must: ( )*

a. *Not provide, or be employed by an agency that provides CSW services to the same participant; and ( )*

b. *For SDCS, meet the conflict of interest standards; ( )*

c. SBs are limited to reimbursement for three thousand one hundred twenty (3,120) hours per calendar year across all participants served unless otherwise authorized by the Department. ( )

***06. Time Sheets and Invoices**. SBs must submit accurate time sheets and invoices for reimbursement or be subject to recoupment. ( )*

811. SUPPORT BROKER (SB) DUTIES AND RESPONSIBILITIES.

***01. Initial Documentation**. Prior to beginning employment for the participant, the SB must type and complete and submit to the participant, the packet of information provided by the FEA. This packet must include documentation of: ( )*

a. SB application approval by the Department; ( )

b. A completed background check, including clearance; and ( )

c. A completed employment agreement in accordance with these rules. The negotiated rate must not exceed the maximum hourly rate for SB services established by the Department. ( )

***02. Documentation**. SB must complete all documentation required by the Department including documentation of the date and type of service provided and billed for. All documentation for services will be retained by the SB for five (5) years. ( )*

***03. Required Duties**. SB services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the SB must: ( )*

a. Assist in facilitating the person-centered planning process as directed by the participant and consistent with the HCBS rules; ( )

b. Develop a written SSP with the participant that includes the paid and unpaid supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. The SSP must be authorized by the Department; ( )

c. Assist the participant to monitor and review their budget; ( )

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; ( )

e. Adhere to Department quality assurance measures; ( )

f. Assist the participant to complete the annual re-determination process as needed, including updating the SSP and submitting it to the Department for authorization; ( )

g. Assist the participant, as needed, to meet the participant responsibilities outlined in these rules and assist the participant, as needed, to protect their own health and safety; ( )

h. Complete the Department-approved background check waiver form when a participant chooses to waive the background check requirement for a CSW. Completion of this form requires that the SB provide education and counseling to the participant and their COS regarding the risks of waiving a background check and assist with detailing the rationale for waiving the background check and how health and safety will be protected; ( )

i. Assist children enrolled in the FDCS option as they transition to adult DD services; ( )

j. Sign the written SSP; ( )

k. Report concerns or discrepancies in documentation and services provided to the Department immediately. ( )

*04. **Additional Duties**. In addition to the required SB duties, each SB must be able to provide the following services when requested by the participant: ( )*

a. Assist the participant to develop and maintain a COS; ( )

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; ( )

c. Assist the participant to negotiate rates for paid CSW; ( )

d. Maintain documentation of supports provided by each CSW and participant's satisfaction with these supports; ( )

e. Assist the participant to monitor community supports; ( )

f. Assist the participant to resolve employment-related problems; ( )

g. Assist the participant to identify and develop community resources to meet specific needs; and ( )

h. Assist the participant in distributing the SSP to CSWs or vendors. ( )

*05. **Termination of Services**. If an SB decides to end services with a participant, they must give the participant and the Department at least thirty (30) days' written notice prior to terminating services. The SB must assist the participant to identify a new SB and provide the participant and new SB with a written service transition plan by the date of termination. The transition plan must include an updated SSP that reflects current supports being received, details about the existing CSWs, and unmet needs. ( )*

812. – 814. (RESERVED)

815. COMMUNITY SUPPORT WORKER (CSW) LIMITATIONS.
A paid CSW must not be the spouse of the participant. For FDCS, they must: 1) not be the parent or legal guardian of the participant; 2) not have direct control over the participant's choices; 3) avoid any conflict of interest; and 4) not receive undue financial benefit from the participant's choices. ( )

*01. **Work Limit**. A CSW for SDCS cannot work more than twelve (12) hours in a day without authorization from the Department. ( )*

*02. **SDCS**. SDCS CSW cannot be younger than seventeen (17) years of age except when providing chore services and then may be sixteen (16) years of age. ( )*

*03. **FDCS**. A paid CSW may provide unskilled supervision, but cannot: ( )*

a. Supplant the role of the parent or legal guardian; ( )

b. Be paid to fulfill any obligations that the parent or legal guardian is legally responsible to fulfill for their child; ( )

c. Be under the age of sixteen (16) years old; or ( )

d. Transport or be left alone with a participant under the age of eighteen (18) years old. ( )

816. PAID COMMUNITY SUPPORT WORKER (CSW) DUTIES AND RESPONSIBILITIES.

*01. **Initial Documentation**. Prior to providing goods or services to the participant, the CSW must type and complete the packet of information provided by the FEA and submit to the FEA. When the CSW will be providing services, this packet must include documentation of: ( )*

a. A completed background check, including clearance or documentation that this requirement has been waived by the participant in accordance with these rules. Individuals listed on a state or federal provider exclusion list must not provide paid supports; ( )

b. A completed employment agreement with the participant in accordance with these rules. If the CSW is provided through an agency, the employment agreement must include the specific individual who will provide the support and the agency's responsibility for tax-related obligations; ( )

c. Current state licensure or certification if identified support requires certification or licensure; and ( )

d. A statement of qualifications to provide supports identified in the employment agreement. ( )

*02. **Employment Agreement**. The CSW must deliver supports as defined in the employment agreement. ( )*

*03. **Documentation**. The CSW must track and document the time required to perform the identified supports and accurately report the time on the time sheets provided by the participant's FEA or complete an invoice that reflects the type of support provided, the date the support was provided, and the negotiated rate for the support provided, for submission to the participant's FEA. Failure to do so may result in recoupment. ( )*

*04. **Time Sheets and Invoices**. The CSW must obtain the signature of the participant or their legal representative on each completed timesheet or invoice prior to submitting the document to the FEA for payment. Time sheets or invoices that are not signed by the CSW and the participant or their legal representative will not be paid. ( )*

817. – 819. (RESERVED)

820. SUPPORT AND SPENDING PLAN (SSP) DEVELOPMENT.

*01. **Requirements**. The participant, with the help of their SB, must develop a comprehensive SSP based on the information gathered during person-centered planning. The person-centered planning process must meet all HCBS requirements. The SSP is not valid until authorized by the Department. The SSP must include: ( )*

a. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in their community. ( )

b. Paid or non-paid supports that focus on the participant's wants, needs, and goals in the following areas: ( )

i. Personal health and safety including quality of life preferences; ( )

ii. Securing and maintaining employment for SDCS; ( )

iii. Establishing and maintaining relationships with family, friends, and others to build the participant's COS; ( )

iv. Learning and practicing ways to recognize and minimize interfering behaviors for SDCS; and ( )

v. Learning new or improving existing skills to accomplish set goals for SDCS. ( )

c. Support needs such as: ( )

i. Medical care and medicine for SDCS; ( )

ii. Skilled care including therapies or nursing needs for SDCS; ( )

iii. Community involvement; ( )

iv. Preferred living arrangements including possible roommate(s); and ( )

v. Response to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any. ( )

d. *Risks or safety concerns in relation to the identified support needs on the participant's SSP. The plan must be active and specify the goods, supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises; ( )*

e. *Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; ( )*

f. *The budgeted amounts planned in relation to the participant's needed supports. The FEA will compare and match the employment agreements to the appropriate support categories identified on the initial SSP prior to processing time sheets or invoices for payment; and ( )*

02. Limitations*. ( )*

a. *Traditional Adult DD waiver services, rehabilitative, or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and CDCS at the same time, the participant, the SB, and the Department must all work together to ensure that there is no interruption of required services when moving between traditional services and the CDCS option; ( )*

b. *Traditional Adult DD waiver services, rehabilitative, or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and CDCS at the same time, the participant, the SB, and the Department must all work together to ensure that there is no interruption of required services when moving between traditional services and the CDCS option; ( )*

c. *All paid community supports must fit into a type of community support described in these rules. The SSP must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, or that violate or infringe on the rights of others; ( )*

d. *SSPs that exceed the approved budget amount will not be authorized; and ( )*

e. *Time sheets or invoices exceeding the authorized SSP amount will not be paid by the FEA. ( )*

821. – 824. (RESERVED)

825. INDIVIDUALIZED BUDGET.
The Department will assign budgets based on the criteria under Subsection 574.01 for adults and Subsection 581.02 for children. ( )

826. – 828. (RESERVED)

829. QUALITY ASSURANCE.
The Department will implement quality assurance processes to ensure: access to CDCS; participant direction of SSPs and services; participant choice and direction of providers; safe and effective environments; and participant satisfaction with services and outcomes. ( )

01. Adult Services Outcome Review (ASOR)*. Each participant will have the opportunity to provide*

feedback to the Department about their satisfaction with consumer-directed services utilizing the ASOR. ( )

***02. Adult Service Outcomes**. Participant experience information will be gathered at least annually in an interview by the Department, and will address the following participant outcomes: ( )*

***a.** Access to care; ( )*

***b.** Choice and control; ( )*

***c.** Respect and dignity; ( )*

***d.** Community integration; and ( )*

***e.** Inclusion. ( )*

***03. CSWs and SBs Quality Assurance Activities**. CSWs and SBs must participate and comply with quality assurance activities identified by the Department including performance evaluations, satisfaction surveys, quarterly review of services provided by a legal guardian, if applicable, and spot audits of time sheets and billing records. ( )*

***04. Participant Choice of Paid CSW**. Paid CSWs must be selected by the participant, or their chosen representative, and meet the qualifications identified in this rule. ( )*

***05. Complaint Reporting and Tracking Process**. The Department will maintain a complaint reporting and tracking process to ensure participants, workers, and other supports have the opportunity to readily report instances of abuse, neglect, exploitation, or other complaints regarding the HCBS program. ( )*

***06. Quality Oversight Committee**. A Quality Oversight Committee consisting of participants, family members, community providers, and Department designees will review information and data collected from the quality assurance processes to formulate recommendations for program improvement. ( )*

***07. Quarterly Quality Assurance Reviews**. On a quarterly basis, the Department will perform an enhanced review of services for those participants who have waived the criminal history check requirement for a community support worker or who have their legal guardian providing paid services. These reviews will assess ongoing participant health and safety and compliance with the approved SSP. ( )*

***08. HCBS Specific Reviews**. The Department will implement quality assurance and improvement activities to ensure compliance with HCBS rules. ( )*

830. FISCAL EMPLOYER AGENT (FEA): DEFINITIONS.
For purposes of Sections 830 through 846, the following definitions apply: ( )

***01. Employee**. A CSW employed by a participant receiving services under the CDCS option. ( )*

***02. Employer**. A participant receiving services under the CDCS option. ( )*

***03. Provider**. The term "provider" specifically refers to the FEA providing FMS to individuals participating in the CDCS option. ( )*

***04. Secure File Transfer Protocol (SFTP)**. A secure means of transferring data that allows certain Department staff to access information regarding CDCS participants. ( )*

***05. Vendor**. Agencies and independent contractors that provide goods and services in accordance with a participant's SSP. ( )*

***06. Medicaid Billing Report**. A report generated every payroll period by the provider; it provides a list and count of unduplicated participants and payroll expenditures by service code, based on the date of service time*

frame specified by the user. ( )

831. FISCAL EMPLOYER AGENT (FEA): REQUIREMENTS AND LIMITATIONS.

***01. Limitations**. The FEA must not:* ( )

***a.** Provide any other direct services to the participant, to ensure there is no conflict of interest; or* ( )

***b.** Employ the guardian, parent spouse, payee, or conservator of the participant or have direct control over the participant's choice.* ( )

832. FISCAL EMPLOYER AGENT (FEA): DUTIES AND RESPONSIBILITIES.

The FEA performs FMS for each participant. Prior to providing FMS the participant and the FEA must enter into a written agreement. FMS include: ( )

***01. Payroll and Accounting**. Providing supports to participants that have chosen the CDCS option including:* ( )

***a.** An online electronic time sheet entry for participants;* ( )

***b.** Processing time sheets for CSWs and SBs, as authorized by the participant, according to the participant's Department-authorized SSP; and* ( )

***c.** Issuing payroll checks after receipt of completed, approved time sheets.* ( )

***02. Recoupment**. Recoup payments made in error when identified by the FEA or the Department by either deducting from future payments or requiring repayment.* ( )

***03. Financial Reporting**. Performing financial reporting for employees of each participant.* ( )

***04. Information Packet**. Preparing and distributing a packet of information, including Department-approved forms for agreement, for the participant hiring their own staff.* ( )

***05. Labor Laws**. Ensure each participant's compliance with all applicable labor laws.* ( )

***06. Taxes**. Ensure each participant's compliance with regulations for both federal and state taxes, including preparation and submission of all federal and state forms for each participant and their employees. Manage and process payment of required state and federal employment taxes for the participant's CSWs and SB.* ( )

***07. Payments of Goods and Services**. Process and pay invoices for goods and services, as authorized by the participant, according to the participant's SSP.* ( )

***08. Spending Information**. Providing each participant with reporting information that will assist the participant with managing the individualized budget.* ( )

***09. Quality Assurance and Improvement**. Participating in Department quality assurance activities.* ( )

833. FISCAL EMPLOYER AGENT (FEA): CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS).

***01. Federal Tax ID Requirement**. The FEA must obtain a separate Federal Employer Identification Number (FEIN) specifically to file tax forms and to make tax payments on behalf of program participants. In addition, the provider must:* ( )

***a.** Maintain copies of the participant's FEIN, IRS FEIN notification letter, and Form SS-4 Request for*

FEIN in the participant's file. ( )

b. *Retire participant's FEIN when the participant is no longer an employer under CDCS. ( )*

02. Requirement to Report Irregular Activities or Practices*. The provider must report to the Department any facts regarding irregular activities or practices that may conflict with federal or state rules and regulations. ( )*

03. Policies and Procedures*. The provider must maintain a current manual containing comprehensive policies and procedures. The provider must submit the manual and any updates to the Department for approval. ( )*

04. Key Contact Person*. The provider must provide a key contact person and at least (2) two other people for backup who are responsible for answering calls and responding to e-mails from Department staff and respond to the Department within one (1) business day. ( )*

05. Face-to-Face Transitional Participant Enrollment*. The provider must conduct face-to-face transitional participant enrollment sessions in group settings or with individual participants in their homes or other designated locations. The provider must work with the regional Department staff to coordinate and conduct enrollment sessions. The face-to-face encounter may occur via virtual care. ( )*

06. SFTP Site*. The provider must provide an SFTP site for the Department to access with the capability of allowing participants and their employees to access individual specific information such as time cards and account statements. The site must be user name and password protected. The provider must have the site accessible to the Department upon commencement of the readiness review. ( )*

07. Required IRS Forms*. The provider must prepare, submit, and revoke the following IRS forms in accordance with IRS requirements and must maintain relevant documentation in each participant's file including: ( )*

a. *IRS Form 2678; ( )*

b. *IRS Approval Letter; ( )*

c. *IRS Form 2678 revocation process; ( )*

d. *Initial IRS Form 2848; and ( )*

e. *Renewal IRS Form 2848. ( )*

08. Requirement to Obtain and Revoke Power of Attorney*. The provider must obtain an Idaho State Tax Commission Power of Attorney (ID-POA) from each participant it represents, revoke the Form ID-POA when the provider no longer represents the participant, and maintain the relevant documentation in each participant's file. ( )*

834. FISCAL EMPLOYER AGENT (FEA): CUSTOMER SERVICE.

01. Customer Service System*. The provider must provide a customer service system to respond to all inquiries from participants, employees, agencies, and vendors. The provider must: ( )*

a. *Provide staff with customer service training with an emphasis on consumer-direction. ( )*

b. *Ensure staff are trained and have the skills to assist participants with enrollment and to help them understand their account statements. ( )*

c. *Ensure that FEA personnel are available during regular business hours. ( )*

d. Provide translation and interpreter services. ( )

e. Provide prompt and consistent response to verbal and written communication. Specifically: ( )

i. All calls and voice mails must be responded to within one (1) business day; and ( )

ii. All written and electronic correspondence must be responded to within five (5) business days. ( )

f. Maintain a toll-free phone line where callers speak to a live person during business hours and are provided the option to leave voice mail at any time. ( )

g. Maintain a toll-free fax line that is available at any time, exclusively for participants and their employees. ( )

h. Maintain an e-mail address. ( )

*02. **Complaint Resolution and Tracking System**. The provider is responsible for receiving, responding to, and tracking all complaints from any source under this agreement and corrective actions. A complaint is defined as a verbal or written expression of dissatisfaction about FEA services. The provider must: ( )*

a. Respond to all written and electronic correspondence within five business (5) days. ( )

b. Respond to all calls and voicemails within one (1) business day. ( )

c. Maintain an electronic tracking system and log of complaints and resolutions accessible for Department review through the SFTP site. ( )

d. Log and track complaints received from the Department pertaining to FEA services. ( )

e. Compile a quarterly summary report analyzing complaints to determine the quality of services to participants and to identify any corrective action necessary. ( )

f. Implement corrective action within one (1) business day of the complaint response. ( )

g. Post the complaint to the SFTP site within one (1) business day. Failure to comply will result in a fifty dollar ($50) penalty payable to Medicaid within ninety (90) days of incident. ( )

835. FISCAL EMPLOYER AGENT (FEA): PERSONAL AND CONFIDENTIAL INFORMATION.
The provider must implement and enforce policies and procedures regarding documents that are mailed, faxed, or emailed to and from the provider to ensure documents are tracked and that confidential information is not compromised, is stored appropriately and not lost, and is traceable for historical research purposes. ( )

836. FISCAL EMPLOYER AGENT (FEA): ENROLLMENT PROCESS.

*01. **Submission of Participant Enrollment and Employee Packets for Department Approval**. The provider must submit the following for participant enrollment and employee packets to the Department for approval. ( )*

a. The participant enrollment packet must include: ( )

i. FEA authorization form; ( )

ii. Employer Appointment of Agent - IRS Form; ( )

iii. Tax Information Form; and ( )

iv. Employer information including; ( )

(1) Instructions for completing forms; ( )

(2) Payroll schedule, including deadlines for submission of time cards; ( )

(3) Sample employment agreements; ( )

(4) Sample Request for Vendor Payment form; ( )

(5) Sample independent provider agreement; and ( )

(6) Other sample employment agreements as needed. ( )

***b.** The employee enrollment packet must contain: ( )*

i. Employee Information Form; ( )

ii. I-9 Employment Eligibility Form; ( )

iii. W-4 Employee Withholding Allowance Certificate; ( )

iv. Pay selection agreement; ( )

v. Direct deposit authorization (optional); and ( )

vi. Sample time sheets and instructions for completion. ( )

***02. Distribution of Participant Enrollment and Employee Packets to Participant after Department Approval**. The provider must distribute Department-approved participant enrollment packets and employment packets to the participant within two (2) business days after the participant requests the packets. ( )*

***a.** To enroll a participant, the provider must: ( )*

i. Enroll the participant within two (2) business days of receipt of completed paperwork; and ( )

ii. Log and maintain an electronic record of all enrollment paperwork, which includes participant SSP cost and authorization sheets. ( )

***b.** To enroll an employee, the provider must: ( )*

i. Enroll the employee within two (2) business days of receipt of completed paperwork; and ( )

ii. Log and maintain an electronic record of all the employee's paperwork that includes the employment agreements. ( )

837. FISCAL EMPLOYER AGENT (FEA): PAYMENT PROCESS.

***01. Process Payroll**. The provider must process payroll, including time sheets and taxes, in accordance with the participant's SSP. The payroll process must include: ( )*

***a.** Payment of employer and withholding taxes to State Tax Commission and Internal Revenue Service. ( )*

***b.** Payment of invoices to vendors. ( )*

***c.** Management of participant budget funds as per authorized SSP. ( )*

d. Garnishment of wages as per court orders. ( )

e. Preparation of year-end federal and state tax forms. ( )

f. Payment of worker's compensation insurance premiums. ( )

*02. **Requirement to Track and Log Time Sheet Billing Errors**. The provider must track and log time sheet billing errors or time sheets that cannot be paid due to late arrival, missing, or erroneous information. The provider must notify the employee and participant within one (1) business day of when errors are identified on the time sheets. ( )*

*03. **Requirement to Track and Log Improperly Cashed or Improperly Issued Checks**. The provider must track and log occurrences of improperly cashed or improperly issued checks and stop payment on checks when necessary. The provider must reissue lost, stolen, or improperly issued checks at no expense to the participant or the Department within fourteen (14) calendar days of when the error occurred. ( )*

*04. **Process Employee Payments**. The provider must verify documentation and process payments via the preference of employees. The employee payment process includes: ( )*

a. Receipt of time cards from employees via mail, fax, or website by specified due dates. ( )

b. Review time cards for accuracy and verify that timecards contain the following information: ( )

i. Employer name and ID number. ( )

ii. Employee name and ID number. ( )

iii. Hours of work. ( )

iv. Code for service. ( )

c. Match codes to employment agreement to verify rate of pay. ( )

d. Verify that rate of pay multiplied by the hours worked per each pay period is equal to the gross pay. ( )

e. Calculate all taxes and other withholding. ( )

f. Pay employees every two (2) weeks or semi-monthly. ( )

g. Contact participant and representative to resolve problems with timecards or other documents prior to pay-date, if possible. ( )

h. Maintain an electronic complaint log of payroll issues and resolutions. ( )

i. Verification of any money remaining in each participant's budget and specific service category prior to issuing payment. ( )

*05. **Process Vendor Payments**. When participants submit requests for payment to vendors, the provider must: ( )*

a. Review, and maintain on file, the vendor payment request with attached voided vendor receipt submitted by the participant. ( )

b. Ensure item or payment is authorized on the participant's SSP. ( )

c. Issue payment to the vendor on the same schedule as payroll. ( )

*06. **Process Independent Contractor or Outside Agency Payments**. When the participant hires an independent contractor or outside agency, in accordance with the SSP, the provider must: ( )*

a. Obtain a W-9 from the contractor or agency. ( )

b. Review, and maintain on file, the independent contractor or agency agreement submitted by the participant. ( )

c. Review, and maintain on file, the independent contractor or agency invoice for services submitted by the participant. ( )

d. Ensure service or payment is authorized on the SSP. ( )

e. Issue payment directly to the independent contractor or agency. ( )

*07. **End-of-Year Processing**. For purposes of end-of-year processing, the provider must maintain relevant documentation and must: ( )*

a. Refund over-collected Federal Insurance Contributions Act tax (FICA) to applicable employees, or to state government; ( )

b. Prepare, file, and distribute IRS Form W-2 for each employee; ( )

c. Prepare and file IRS Form W-3 for each participant represented; ( )

d. Prepare and file State Form 967 for state income taxes withheld for each employer; ( )

e. Report and pay any Unclaimed Property per Idaho State Tax Commission rules; and ( )

f. Report and pay all state and federal unemployment insurance premiums. ( )

*08. **Transition to New FEA**. The following items must be addressed if a participant transitions to a new FEA provider. For the purposes of a smooth transition between FEA providers, the two (2) providers must work closely with one (1) another to transfer the participant from the services one (1) is no longer providing to the services the other is providing. The following items must be transferred: ( )*

a. Participant's FEIN and FEIN mailing address. ( )

b. IRS Form 2678 Agent/Payer Authorization. ( )

c. Depositing taxes and filing report. This includes Federal and State tax withholdings and Federal Unemployment Tax Act tax (FUTA). ( )

d. Participant's FUTA Liability Status. ( )

e. FICA and FUTA Exemption Status of Participant Employees. ( )

f. Unemployment Insurance (U/I). ( )

g. Unemployment Insurance Experience Rate and Taxable Wage Base. ( )

h. State Unemployment Insurance Liability Status of the Participant and Exempt Employees. ( )

i. Unemployment Insurance Filing and Depositing. ( )

j. State Income Tax - Account Number Agent Authorization, Filing and Depositing. ( )

k. Budget Authorization - Authorized Services Spent and Remaining, Authorized Providers, and Authorized Provider Rates. ( )

l. Participant's Representative, and Participant's Employee and Provider Demographic Information. ( )

m. Participant's Employee New Hire Reporting, Liens and Garnishments, and Tax and Other Information. ( )

n. Participant's Independent contract and other information. ( )

838. FISCAL EMPLOYER AGENT (FEA): ANNUAL PARTICIPANT SURVEY.

*01. **Requirement to Conduct Annual Participant Satisfaction Survey**. Starting October 1 of each calendar year, each provider who has been providing services for at least six (6) months must conduct an annual participant satisfaction survey. ( )*

a. Three (3) weeks prior to the survey launch, the provider must present the questions to the Department staff for approval. ( )

b. Once the questions are approved by the Department, the provider can send out the survey. ( )

c. The provider must survey its participants who receive services under the CDCS option, including those whose primary language is other than English. ( )

d. The provider must provide options for participants to respond to the surveys, other than by mail. ( )

*02. **Requirement to Provide Results of Annual Participant Satisfaction Survey**. The provider must provide the results of the surveys to the Department in a comprehensive report, along with the completed surveys, by the 15th of December each calendar year. ( )*

839. FISCAL EMPLOYER AGENT (FEA): QUALITY ASSURANCE.

*01. **Quality Assurance Activities**. The FEA must participate in quality assurance activities identified by the Department such as readiness reviews, periodic audits, maintaining a list of background check waivers, and timely reporting of accounting and satisfaction data. ( )*

*02. **Elements of Quality Assurance Process**. The provider must provide a quality assurance process that includes: ( )*

a. Implementation of a quality management plan; ( )

b. Preparation of a quarterly, quality management analysis report; ( )

c. Distribution, collection, and analysis of an annual participant satisfaction survey; and ( )

d. A review of the monthly complaint summary and resolutions, monitoring of standards, and implementation of program improvements as needed. ( )

*03. **Formal Quality Assurance Review**. Every two (2) years, the provider must participate in a formal quality assurance review conducted in collaboration with the Department. ( )*

840. FISCAL EMPLOYER AGENT (FEA): DISASTER RECOVERY PLAN.

*01. **Disaster Recovery Plan**. The provider must develop and maintain a Disaster Recovery Plan for electronic and hard copy files that includes restoring software and data files, and hardware backup if management information systems are disabled or servers are inoperative. The results of the Disaster Recovery Plan must ensure the continuation of payroll and invoice payment systems. The provider must submit the Disaster Recovery Plan for Department approval during the readiness review. ( )*

*02. **Requirement to Report a Disaster**. The provider must report to the Department if management information systems are disabled or servers are inoperative within twenty-four (24) hours of the event. ( )*

841. FISCAL EMPLOYER AGENT (FEA): TRANSITION PLAN.

*01. **Transition Plan Objectives**. The provider must provide a transition plan to the Department for the readiness review. The objectives of the transition plan are to minimize the disruption of services and provide an orderly and controlled transition of the provider's responsibilities to a successor at the conclusion of the agreement period or for any other reason the provider cannot complete responsibilities described in this chapter of rules. ( )*

*02. **Transition Plan Requirements**. The transition plan must: ( )*

a. Be updated at least ninety (90) days prior to termination of the provider agreement. ( )

b. Include tasks, and subtasks for transition, a schedule for transition, operational resource requirements, and training to be provided. ( )

c. Provide for transfer of data, documentation, files, and other records relevant to the agreement in an electronic format accepted by the Department. ( )

d. Provide for the transfer of any current, Idaho-specific policy and procedure manuals, brochures, pamphlets, and all other written materials developed in support of agreement activity to the Department. ( )

842. FISCAL EMPLOYER AGENT (FEA): PERFORMANCE METRICS.

*01. **Readiness Review**. Complete a readiness review conducted by the Department with the provider prior to providing FEA services. ( )*

a. The Department will access SFTP site for review of provider documents and conduct an onsite reviews. ( )

*02. **Fiscal Support and Financial Consultation**. The provider must provide each participant with fiscal support and financial consultation. ( )*

*03. **Quarterly Reconciliation**. Each fiscal quarter after initiating service, the provider must reconcile its Medicaid Billing Report to a zero-dollar ($0) balance with the Medicaid Bureau of Financial Operations. The provider has ninety (90) days to comply with reconciling each participant's SSP balance to a zero dollar ($0) balance with Medicaid's reimbursements. The provider must: ( )*

a. Show one hundred percent (100%) compliance with the required quarterly reconciliation of the Medicaid Billing Report. ( )

b. Notify the Department immediately if an issue is identified that may result in the provider not reconciling the Medicaid Billing Report. The Department will notify the provider when a performance issue is identified. The Department may require the provider to submit a written corrective action plan for Department approval within two (2) business days after notification. If the provider fails to reconcile within ninety (90) days after the end of each quarter, the provider will be penalized fifty dollars ($50) each week until the provider has reconciled with Medicaid to a zero dollar ($0) balance. ( )

*04. **Cash Management Plan**. Each provider's cash management plan must equal one point five (1.5) times the monthly payroll cycle amount and can be forms of liquid cash and lines of credit. For example, if a provider's current payroll minimum has averaged one hundred thousand dollars ($100,000) per payroll cycle, the provider would be required to have one hundred fifty thousand dollars ($150,000) in a cash management plan. The Department must be on the notification list if any lines of credit are decreased in the amount accessible or terminated. The expectation is to provide a seamless payroll cycle to the participant, without loss of pay to their employees.* ( )

843. FISCAL EMPLOYER AGENT (FEA): REPORTS.

*01. **Account Summary Statements**. This report provides an overview of each participant account and includes the services accessed and the remaining dollar amount in the budget as well as information on how to read the report. In addition to providing this monthly report, a participant may request this report for a specified timeframe. Each month, the provider must at the participant's preference mail a hard copy of the report to each participant or make the report available on a secure website. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site must have a user name and password protection.* ( )

a. Report Format: Microsoft Excel. ( )

b. Report Due Date: The 10th day of each month. ( )

*02. **Medicaid Billing Report**. This report provides a detailed breakdown of CSW services rendered by service date per employee, per employer. Each line on this report must provide the following information: employee name and ID number, hours worked, period start, and period end, pay rate, service date, check number and date, participant's name, participant's date of birth, participant's ID number, service code, taxes, and billing amount. This report collects information based on the timeframe specified by the user. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access.* ( )

a. Report Format: Microsoft Excel. ( )

b. Report Due Date: The 10th day of each month. ( )

*03. **Demographic Report**. This report provides general client demographics in the region and the employee count per participant for each participant in the database. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access.* ( )

a. Report Format: Microsoft Excel. ( )

b. Report Due Date: The 10th day of each month. ( )

*04. **Background Check Report**. This report provides a breakdown, by participant, of which employees the participant waived the background check, which employees passed or failed the background check, the background check reference number, and the date the background check was submitted. This report does not include SBs. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access.* ( )

a. Report Format: Microsoft Word, Microsoft Excel, or PDF. ( )

b. Report Due Date: The 10th day of each month. ( )

*05. **Medicaid Billing Report**. This report provides a list and count of the unduplicated participants and expenditures by services code based on the time frame specified by the user. The provider must generate the report after every payroll and post it on a SFTP site. Additionally, the provider must provide a quarterly Medicaid Billing Report that can been reconciled quarterly and work with the Department to reconcile the annual report.* ( )

a. Report Format: Microsoft Excel. ( )

b. Report Due Date: The 10th day of each month. ( )

*06. **Complaint and Resolution Summary Report**. The provider must analyze complaints received on a quarterly basis to determine the quality of services to participants and identify any corrective actions and program improvements needed and implemented. The provider must post the report on a secure SFTP site for Department review. ( )*

a. Report Format: Microsoft Word, Microsoft Excel, or PDF. ( )

b. Report Due Date: The 10th day of the month following the end of each annual quarter. ( )

*07. **Customer Satisfaction Survey Report**. The provider must provide a comprehensive report summarizing the results of the customer satisfaction survey completed by each participant. ( )*

a. Report Format: Microsoft Word, Microsoft Excel, or PDF. ( )

b. Report Due Date: December 1st of each year. ( )

*08. **Quarterly Financial Statements**. The provider must provide the Department a quarterly balance sheet and income statement that shows the provider's quarterly financial status and cash management plan cash reserve. ( )*

a. Report Format: Microsoft Word, Microsoft Excel, or PDF. ( )

b. Report Due Date: The 25th day of the month following the end of each annual quarter. ( )

844. FISCAL EMPLOYER AGENT (FEA): PAYMENT REQUIREMENTS.

*01. **Per Member Per Month (PMPM) Payment**. The Department will pay, and the provider must accept a PMPM payment that covers a comprehensive set of FEA services. The Department will set allowable reimbursement rates for PMPM based on a methodology approved by CMS in the Adult DD Waiver. The provider can only bill the PMPM rate for the months services are actually provided for participants, The provider must provide transition, training, and closeout services during the active agreement, at no additional cost to the Department. ( )*

*02. **PMPM Payment Process Requirements**. The PMPM payment must include all administrative costs, travel, transition, training, and closeout services. The Department will not pay for participants who do not have an SSP. For the purposes of PMPM payment, one (1) month must include all payroll batch dates within that specific calendar month. ( )*

*03. **Readiness Review**. The provider must complete a readiness review prior to billing for services. ( )*

845. TERMINATION OF FISCAL EMPLOYER AGENT (FEA) PROVIDER AGREEMENTS.

In the event of termination of a provider agreement, the provider must: ( )

*01. **Continuation of Services**. Ensure continuation of services to participants for the period in which a PMPM payment has been made, and submit the information, reports and records, including the Medicaid Billing Report as specified in these rules. ( )*

*02. **Advanced Notice**. Provide to the Department a written notice ninety (90) days in advance and the change notification must occur at the end of the next calendar quarter. ( )*

*03. **Termination of Service**. Provide to the participant a written notice ninety (90) days in advance. The change notification must occur at the end of the next calendar quarter. ( )*

846. REMEDIES TO NONPERFORMANCE OF A FISCAL EMPLOYER AGENT (FEA) SERVICE PROVIDER.

***01. Remedial Action**. If any of the services do not comply with the performance metrics under these rules, the Department will consult with the provider and may, at its sole discretion, require any of the following remedial actions, taking into account the scope and severity of the noncompliance, compliance history, the integrity of the program, and the potential risk to participants. ( )*

***a.** Require the provider to take corrective action to ensure that performance meets the performance metrics under Section 842 of these rules; ( )*

b. Reduce payment to reflect the reduced value of services received; ( )

c. Require the provider to subcontract all or part of the service at no additional cost to the Department; ( )

d. Terminate the provider agreement with notice. ( )

***02. Direct Monetary Action**. If any of the performance metrics under Section 842 of these rules are not met, the Department will enforce a fifty dollar ($50) a week penalty for each performance metric not met. The penalty will be captured prior to any payment from the Department to the provider. ( )*

847. – 959. (RESERVED)

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.05 – SELF-FUNDED HEALTH CARE PLANS RULE

DOCKET NO. 18-0405-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 41-211 and 41-4020, 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:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. This chapter supplements the provisions of Title 41, Chapter 40, Idaho Code, Self-Funded Health Care Plans by providing application requirements, dates, definitions, effective dates; and requirements for contribution rates, contracts, services, and records.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025 Idaho Administrative Bulletin, Vol. 25-8, pages 56-60.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.06 – GOVERNMENTAL SELF-FUNDED EMPLOYEE HEALTH CARE PLANS RULE

DOCKET NO. 18-0406-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 41-211, 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:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. This chapter is to supplement the provisions of Title 41, Chapter 41, Idaho Code, Joint Public Agency Self-Funded Health Care Plans by providing application requirements, rules, dates, and definitions.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 61-64.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.11 – LONG-TERM CARE INSURANCE MINIMUM STANDARDS

DOCKET NO. 18-0411-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 41-211 and 41-4608, 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:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The purpose of this chapter is to promote the public interest and availability of long-term care insurance coverage. The intent is to protect applicants from unfair sales and enrollment practices and facilitate public understanding, comparison, flexibility, and innovation in the development of long-term care insurance.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 65-100.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.12 – THE SMALL EMPLOYER HEALTH INSURANCE AND AVAILABILITY ACT

DOCKET NO. 18-0412-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 41-211 and 41-4715, 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:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The purpose of this chapter is to promote broader spreading of risk in the small employer marketplace.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 101-118.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.13 – THE INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT

DOCKET NO. 18-0413-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 41-211 and 41-5211, 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:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code negotiated rulemaking was conducted. The purpose of this chapter promotes broader spreading of risk in the individual marketplace.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 119-134.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.14 – COORDINATION OF BENEFITS

DOCKET NO. 18-0414-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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) 41-211 and 41-2141, and 41-2216, 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:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The purpose of this chapter allows plans to include a coordination of benefits (COB) provision; establish a uniform order of benefit determination; provides authority for the transfer of information and funds; reduces duplication of benefits and claim payment delays; requires COB provisions be consistent with this rule; and provides efficiency in processing claims.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 135-144.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

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IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.15 – RULES GOVERNING SHORT-TERM HEALTH INSURANCE COVERAGE

DOCKET NO. 18-0415-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE AND TEMPORARY RULE

EFFECTIVE DATE: The effective date of this temporary rule is October 15, 2025. The pending rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. If the Legislature approves the pending rule, it will become final and effective on July 1, 2026, unless the concurrent resolution states a different effective date.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule and a pending rule. The action is authorized pursuant to Sections 67-5226, 41-211, 41-4207, and 41-5214, Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a pending rule:

This pending rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. This chapter implements Title 41, Chapter 21, 42, and 52, Idaho Code regarding short-term limited-duration insurance by defining requirements for enhanced short-term plans and nonrenewable short-term coverage, including minimum standards for benefits, rating rules, enrollment, renewability, and required disclosure provisions.

Due to recent events, the Department of Insurance (DOI) determined that a temporary rule is necessary to (A) protect public health and safety and (B) to reduce a regulatory burden. Further, on August 7, 2025, the U.S. Departments of Labor, HHS, and Treasury (hereinafter, the "Federal Departments") issued a statement that the Federal Departments do not intend to prioritize enforcement actions for violations related to failing to meet the definition of Short-Term Limited Duration Insurance (STLDI) related to the 2024 rules.

Acting on this guidance, the DOI is authorizing carriers and producers that sell STLDI to follow the durations set forth under this temporary rule. https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/short-term-limited-duration-insurance/stldi-statement-08-07-2025.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 145-151.

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

Due to recent increases in the cost of health insurance and the expiration of the enhanced tax credit, Idaho consumers are faced with a significant impact on their ability to obtain coverage. This temporary rule is necessary to protect public health and safety by ensuring that Idahoans have the ability to access Short-Term Limited Duration Insurance (STLDI) during open enrollment which commences on October 15.

Additionally, the DOI sought to eliminate burdensome requirements or regulations that were costly or harmful to consumers. For example, the DOI removed the 6-month duration maximum on traditional STLDI, instead allowing such plans to continue until the end of the calendar year.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 20th day of October, 2025.

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DOCKET NO. 18-0415-2501 - ADOPTION OF PENDING RULE AND TEMPORARY RULE

No substantive changes have been made to the pending rule.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 25-8, August 6, 2025, pages 145 through 151.

This rule has been adopted as a pending rule by the Agency and is now awaiting review and final approval by the 2026 Idaho State Legislature.

Pursuant to Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin.

THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE FOR DOCKET NO. 18-0415-2501
(Entire ZBR Chapter Rewrite Printed)

18.04.15 – RULES GOVERNING SHORT-TERM HEALTH INSURANCE COVERAGE

000. LEGAL AUTHORITY.
~~Title 41, Chapters 2, 21, 42, and 52~~Section 41-211, Section 41-4203, Section 41-4204, and Section 41-5211, Idaho Code. ~~(3-31-22)~~(10-15-25)T

001. ~~TITLE AND~~ SCOPE.

~~01.~~ ~~Title~~. ~~IDAPA 18.04.15, "Rules Governing Short-Term Health Insurance Coverage."~~ ~~(3-31-22)~~

~~02.~~ ~~Purpose and Scope~~. ~~I~~This chapter implements Title 41, Chapters 21, 42, and 52, Idaho Code~~, regarding short-term, limited-duration insurance by defining rules for enhanced short-term plans and nonrenewable short-term coverage, including minimum standards for benefits, rating rules, enrollment, renewability, and disclosure provisions~~. ~~(3-31-22)~~(10-15-25)T

~~03. Applicability. This rule applies to all enhanced short-term plans and nonrenewable short-term coverage that provide medical expense coverage.~~ (3-31-22)

002. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to the applicable definitions in Chapters 21, 42, and 52, Idaho Code, the following definitions apply: (3-31-22)

01. Benchmark Medical Plan. The health benefit plan identified by the U.S. Department of Health and Human Services to be applicable in establishing minimum benefit coverages by Qualified Health Plans within Idaho, excluding any supplements for pediatric dental or vision. (3-31-22)

02. Exchange. Has the meaning set forth in Section 41-6103, Idaho Code. (3-31-22)

03. Nonrenewable Short-term Coverage. Short-term, limited-duration insurance that is not renewable, has a total duration ~~of six (6) months or less in total~~ not to exceed twelve (12) months, and does not extend past the end of the current calendar year, and is not an Enhanced Short-term Plan ~~under Section 41-5203(11), Idaho Code, and this rule~~. ~~(3-31-22)~~(10-15-25)T

~~04. Preexisting Condition.~~ ~~(3-31-22)~~

~~a. A condition for which an ordinarily prudent person would seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;~~ ~~(3-31-22)~~

~~b. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or~~ ~~(3-31-22)~~

~~c. A pregnancy existing on the effective date of coverage.~~ ~~(3-31-22)~~

0~~5~~4. **Qualified Health Plan or QHP**. A health plan certified as such by the Exchange. (3-31-22)

0~~6~~5. **Reissuance or Replace**. The practice of issuing a short-term, limited-duration insurance policy covering at least one individual having short-term, limited-duration insurance coverage within sixty-three (63) days of the policy's effective date. (3-31-22)

0~~7~~6. **Short-term, Limited-duration Insurance**. Health insurance coverage pursuant to a contract that has a specified expiration date less than twelve (12) months after the original effective date of the contract and, including renewals or extensions, has a total duration of no longer than thirty-six (36) months. (3-31-22)

011. GENERAL RULES FOR ~~ENHANCED~~ SHORT-TERM ~~PLANS~~, LIMITED-DURATION INSURANCE.
Short-term, Limited-duration Insurance is subject to the provisions of IDAPA 18.04.13, Sections 081, 082, and 101. (10-15-25)T

012. GENERAL RULES FOR ENHANCED SHORT-TERM PLANS.

01. Application of Requirements. Any short-term, limited-duration insurance that, including renewals, reissuance or extensions, has a total duration of ~~longer than six (6)~~ twelve (12) months or longer is subject to the requirements applicable to enhanced short-term plans. ~~(3-31-22)~~(10-15-25)T

02. Guaranteed Issue. Enhanced short-term plans are only to be offered on a guaranteed issue basis. (3-31-22)

03. Portability. Enhanced short-term plan coverage is qualifying previous coverage ~~under Title 41, Chapter 52, Idaho Code. Preexisting condition exclusions are to be waived for the period of time an individual was previously covered by an enhanced short-term plan or other qualifying previous coverage~~. ~~(3-31-22)~~(10-15-25)T

04. Requirement to Offer Exchange Plans. To offer an enhanced short-term plan, a carrier is to offer individual QHPs through the Exchange in the same service area. (3-31-22)

~~**012. GENERAL RULES FOR NONRENEWABLE SHORT-TERM COVERAGE.**~~
~~Nonrenewable short-term coverage is subject to the provisions of IDAPA 18.04.13, Sections 081, 082, and 101.~~ ~~(3-31-22)~~

013. -- 019. (RESERVED)

020. ENROLLMENT.

~~**01. Enhanced Short-term Plans**. There are two exclusive options for enhanced short-term plan enrollment.~~ ~~(3-31-22)~~

~~a~~**01. Year-round Enrollment**. ~~If a~~ A carrier will allow~~s~~ year-round enrollment ~~in enhanced short-term plans, the following provisions apply:~~. ~~(3-31-22)~~(10-15-25)T

~~i~~**02. Preexisting Conditions**. A preexisting condition exclusion period~~, as defined at Subsection 010.04,~~ may be applied, subject to Section 41-5208, Idaho Code. ~~(3-31-22)~~(10-15-25)T

~~ii. The policy is to be offered on a plan year basis, not a calendar year basis.~~ ~~(3-31-22)~~

~~**b.** Annual Open Enrollment Period. If a carrier restricts enrollment in enhanced short-term plans to an annual open enrollment period, the following apply:~~ ~~(3-31-22)~~

~~i. No preexisting condition exclusion period may be applied.~~ ~~(3-31-22)~~

~~ii. The beginning and ending dates of the open enrollment period are identical to those for enrollment in QHPs, unless the Director allows an extension of the open enrollment period for enhanced short-term plans after determining it is in the public interest.~~ ~~(3-31-22)~~

~~iii. Special enrollment periods are to be allowed to the same extent as QHP enrollment.~~ ~~(3-31-22)~~

~~**02. Nonrenewable Short-term Coverage**. Nonrenewable short-term coverage is to be offered on a year-round basis.~~ ~~(3-31-22)~~

021. RENEWAL AND REISSUANCE.

01. Enhanced Short-term Plans Renewals. (3-31-22)

a. A policy is to be renewable at the option of the enrollee, consistent with Section 41-5207, Idaho Code. (3-31-22)

b. No new application or questions concerning the health or medical condition of the covered individuals may be requested to effectuate the renewal. (3-31-22)

~~**c.** A policy is not to be renewable beyond thirty-six (36) consecutive months.~~ ~~(3-31-22)~~

~~d~~**c.** Upon exhaustion of a policy's renewability due to duration or age, the policyholder is eligible for enrollment into fully renewable coverage, including all of the current carrier's QHPs~~, when an enhanced short-term policy has been in effect for at least eleven (11) months~~. The carrier will provide to the policyholder ~~T~~timely notification of eligibility ~~is to be provided to the policyholder~~ plus the notification of any offer of reissuance. ~~(3-31-22)~~(10-15-25)T

02. Enhanced Short-term Plans Reissuances. Upon exhausting renewability due to duration or age, the following provisions apply to reissuance: (3-31-22)

a. No new application or questions concerning the health or medical condition of the covered individuals may be requested for reissuance. (3-31-22)

b. The reissuance premium rate is a change in premium rate subject to ~~IDAPA 18.04.13.036.17~~ Section 41-5206, Idaho Code. ~~(3-31-22)~~(10-15-25)T

03. Nonrenewable Coverage. Carriers are not to renew nonrenewable short-term coverage and are not to reissue or replace nonrenewable short-term coverage issued by the same or another carrier. (3-31-22)

022. RATING REQUIREMENTS.

01. Enhanced Short-term Plans. In addition to the requirements applicable to individual health benefit plans, the following rating requirements apply: (3-31-22)

a. Premium rates do not vary by gender. (3-31-22)

b. Geographic rating areas are identical to those used for Exchange-offered QHPs. (3-31-22)

c. Medical underwriting criteria may be used to ascertain the risk characteristics of an applicant, if the criteria are limited to those in the Universal Health Statement Addendum and available claims data. (3-31-22)

~~**d.** Enhanced short-term plans comprise a single risk pool with the carrier's other actively marketed individual health benefit plans subject to Title 41, Chapter 52, Idaho Code.~~ ~~(3-31-22)~~

ed. The rating period is on a calendar year basis, whereby the rates filed apply to all enrollees uniformly during a given calendar year and premium rate changes occur at the start of a new calendar year. (3-31-22)

02. Nonrenewable Short-term Coverage. The following rating requirements apply: (3-31-22)

a. The rates cannot utilize case characteristics other than age, individual tobacco use, and geography but may vary by the duration of coverage requested. (3-31-22)

b. Case characteristics are applied uniformly, without regard to the risk characteristics of an eligible individual. (3-31-22)

c. The premium rate is not affected by an applicant's risk characteristics or health status. (3-31-22)

d. The premium rate remains the same for the duration of the policy. (3-31-22)

023. -- 029. (RESERVED)

030. MINIMUM STANDARDS FOR BENEFITS.

01. Minimum Covered Benefits. ~~(3-31-22)~~

~~**a.** Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;~~ ~~(3-31-22)~~

~~**b.** Miscellaneous hospital services;~~ ~~(3-31-22)~~

~~**c.** Surgical services;~~ ~~(3-31-22)~~

~~**d.** Anesthesia services;~~ ~~(3-31-22)~~

~~**e.** In-hospital medical services; and~~ ~~(3-31-22)~~

~~f. Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician.~~ ~~(3-31-22)~~

~~02. Minimum Additional Benefits. A separate premium corresponding to additional benefits offered through a rider is to be filed and actuarially justified. A policy is to provide not fewer than three (3) of the following additional benefits:~~ ~~(3-31-22)~~

~~a. In-hospital private duty registered nurse services;~~ ~~(3-31-22)~~

~~b. Convalescent nursing home care;~~ ~~(3-31-22)~~

~~c. Diagnosis and treatment by a radiologist or physiotherapist;~~ ~~(3-31-22)~~

~~d. Rental of special medical equipment, as defined by the insurer in the policy;~~ ~~(3-31-22)~~

~~e. Artificial limbs or eyes, casts, splints, trusses or braces;~~ ~~(3-31-22)~~

~~f. Treatment for functional nervous disorders, and mental and emotional disorders; or~~ ~~(3-31-22)~~

~~g. Out-of-hospital prescription drugs and medications.~~ ~~(3-31-22)~~

~~03. Enhanced Short-term Plans Covered Benefits.~~ The following covered benefits and limitations are to be provided, consistent with the Benchmark Medical Plan~~, including:~~. ~~(3-31-22)~~(10-15-25)T

a. Ambulatory (outpatient) patient services; (3-31-22)

b. Emergency services; (3-31-22)

c. Hospitalization; (3-31-22)

~~d. Maternity and newborn care;~~ ~~(3-31-22)~~

~~e. Mental health and substance use disorder services, including behavioral health treatment;~~ ~~(3-31-22)~~

~~f~~d. Generic ~~P~~prescription drugs; ~~(3-31-22)~~(10-15-25)T

~~g~~e. Rehabilitative and habilitative services and devices; and ~~(3-31-22)~~(10-15-25)T

~~h~~f. Laboratory services~~; and~~. ~~(3-31-22)~~(10-15-25)T

~~i. Preventive and wellness services and chronic disease management.~~ ~~(3-31-22)~~

0~~4~~2. **Prescription Drug Formulary**. If a prescription drug coverage formulary is applied, the applicable formulary drug list is to: (3-31-22)

a. Include at least one drug in every United States Pharmacopeia (USP) category and class; (3-31-22)

b. Cover a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all covered disease states, and does not discourage enrollment by any group of enrollees; and (3-31-22)

c. Provide appropriate access to drugs included in broadly accepted treatment guidelines and indicative of then-current general best practices. (3-31-22)

0~~5~~3. **Cost Sharing**. (3-31-22)

a. Except for out-of-network benefits offered as part of a managed care plan, a coinsurance percentage is not to exceed fifty percent (50%) of covered charges. A coinsurance percentage for out-of-network benefits offered as part of a managed care plan is not to exceed sixty percent (60%) of covered charges. (3-31-22)

b. The maximum out-of-pocket is to be stated in the policy and in aggregate is not to exceed ~~four percent (4%) of the aggregate annual limit under the policy for each covered person~~ the limits for QHPs. All deductibles, copayments, coinsurance and any other cost-sharing are applicable to the maximum out-of-pocket. Within the aggregate maximum, the policy may include separate out-of-pocket limits applicable to particular services. ~~(3-31-22)~~(10-15-25)T

c. The annual limit is no less than one million dollars ($1,000,000) for each ~~covered person~~ insured. ~~(3-31-22)~~(10-15-25)T

~~**d.** Enhanced short-term plans are to provide coverage for and not impose any cost sharing requirements for preventive and wellness services consistent with QHP requirements. (3-31-22)~~

~~**06. Applicability of Mental Health Parity**. Enhanced short-term plans are to meet the requirements of Section 2726 of the Public Health Service Act (Mental Health Parity and Addiction Equity Act) in the same manner and extent as QHPs. (3-31-22)~~

0~~7~~4. **Benefit Requirements**. The minimum benefits imposed by Subsections 030.01~~, 030.02, and 030.03~~ may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. Except as ~~dis~~allowed by Subsections 030.03~~, 030.05, and 030.06, a policy may also have special or internal limitations for nursing facilities, transplants, experimental treatments, services covered under Subsection 030.02, and other special or internal limitations authorized by the Director. Except as authorized by this Subsection through the application of special or internal limitations~~, a policy will cover~~, after any deductibles or coinsurance provisions are met,~~ the usual, customary and reasonable charges, as determined consistently by the carrier ~~and as subject to prior written approval by the Director~~ or another rate agreed to between the insurer and provider, for covered services up to the annual limit. ~~(3-31-22)~~(10-15-25)T

031. -- 039. (RESERVED)

040. DISCLOSURE PROVISIONS.
Polices subject to this chapter will include in the application for coverage, any application materials, and the insurance contract, the following language in at least 14-point type:

"This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage." (3-31-22)

041. -- 999. (RESERVED)

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.06.05 – MANAGING GENERAL AGENTS

DOCKET NO. 18-0605-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 41-211, 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:

This rule was presented as part of the Department of Insurance's plan to review each rule according to the Governor's Executive Order 2020-01: Zero-Based Regulation, and pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The purpose of this chapter implements and administers provisions in the Managing General Agent Act, which includes governing qualifications and procedures for acquiring the status as a Managing General Agent.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 152-155.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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: No fiscal impact.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Weston Trexler, (208) 334-4214, weston.trexler@doi.idaho.gov.

DATED this 3rd day of October, 2025.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor
P.O. Box 83720
Phone: (208) 334-4250
Fax: (208) 334-4398

IDAPA 20 – IDAHO DEPARTMENT OF LANDS

20.03.08 – EASEMENTS ON STATE-OWNED LANDS

DOCKET NO. 20-0308-2501 (ZBR 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 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 58-104 and 58-105, Idaho Code, and Title 58 Chapter 6, Idaho Code.

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

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 6, 2025, Idaho Administrative Bulletin, Vol. 25-8, pages 156-162.

The change in the pending rule was to correct an inadvertent deletion of the words "and survey" in section 21.05. Minimum Compensation.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Lawson Tate at 208-920-6865.

DATED this 3rd day of October, 2025.

Lawson Tate, Right-of-Way Program Manager
2550 Highway 2 West
Sandpoint, Idaho 83864
Phone: (208) 263-5104
ltate@idl.idaho.gov

DOCKET NO. 20-0308-2501 - ADOPTION OF PENDING RULE

Substantive changes have been made in the pending rule.
Italicized red text that is *double underscored* indicates
amendments to the proposed text as adopted in the pending rule.

The text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 25-8, August 4, 2025, pages 156 through 162.

This rule has been adopted as a pending rule by the Agency and is now awaiting review and final approval by the 2026 Idaho State Legislature.

THE FOLLOWING IS THE TEXT OF THE PENDING RULE FOR DOCKET NO. 20-0308-2501

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

20.03.08 – EASEMENTS ON STATE-OWNED LANDS

021. FEES AND COMPENSATION.

~~**01. Application Fee**. The application fee for new, renewed, or amended easements is one hundred dollars ($100) and is collected from all applicants. This application fee is in addition to the easement compensation and appraisal costs, and is non-refundable unless the Director determines that the land applied for is not under the jurisdiction of the Board. (3-18-22)~~

~~**02. Easement Fee**. The compensation for permanent easements over state-owned lands covered by these rules is as follows:~~

	~~COMPENSATION~~
~~Highways, roads, railroads, reservoirs, trails, canals, ditches, or any other improvements that require long term, exclusive or near exclusive use and occupation of the right of way~~	~~Up to 100% of land value plus payment for any damage or impairment of rights to the remainder of the property as determined by the Director and supported by specific data such as an appraisal~~
~~Overhead transmission and power lines~~	~~Up to 100% of land value depending on the exclusivity of use as determined by the Director and supported by specific data such as an appraisal plus payment for any damage or impairment of rights to the remainder of the property as determined by the Director and supported by data such as an appraisal~~
~~Buried installations – cables, pipelines, sewerlines, waterlines~~	~~Up to 100% of land value, depending on the exclusivity use as determined by the Director and supported by specific data such as an appraisal plus payment for any damage or impairment of rights to the remainder of the property, as determined by the Director and supported by specific data such as an appraisal~~

~~(3-18-22)~~

~~**03. Appraisal Required**. An appraisal of an easement may be required where, in the opinion of the Director, the easement value will exceed the minimum compensation fee of five hundred dollars ($500). (3-18-22)~~

01. Easement Fee. The compensation for easements over state-owned lands: Up to one hundred percent (100%) of market value, plus payment for any damage or impairment of rights to the remainder of the

property, and proportional payment for any existing improvements within the right-of-way, such as a road, road surfacing, culverts, and bridges, as determined by the Director and supported by specific data such as an appraisal. ( )

a. A commensurate portion of the value created by the right of way, as determined by the Director and supported by specific data such as an appraisal. ( )

042. **Performance of Appraisal**. The appraisal of the easement ~~will normally be~~ may be performed by qualified ~~d~~Department staff or as determined by the Director. ~~If so desired by the applicant, and agreed to by the Director, the applicant may provide the appraisal that is acceptable to and meets the specifications set by the Director.~~ ~~(3-18-22)~~( )

053. **Appraisal Costs**. An Applicant shall bear the costs of an appraisal. Where the appraisal is performed by the ~~d~~Department ~~staff, the appraisal is two hundred fifty dollars ($250) for a market analysis, five hundred dollars ($500) for a short form appraisal, and one thousand dollars ($1,000) for appraisals of easements requiring Board approval. The appraisal cost is in addition to those costs outlined in Subsections 021.01 and 021.02. In no case will~~, an applicant will not be charged more than one thousand dollars ($1000) for an appraisal ~~of an easement conducted by departmental staff~~. ~~(3-18-22)~~( )

064. **Term Easements**. Compensation for term easements will be established by appraisal or as determined by the Director. ~~(3-18-22)~~( )

075. **Minimum Compensation**. The minimum compensation for any easement is ~~five hundred dollars ($500),~~ at the discretion of the Land Board, not including the ~~application fee and~~ appraisal *and survey* costs. ~~(3-18-22)~~( )

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.26.01 – RULES OF MIDWIFERY

DOCKET NO. 24-2601-2501

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code.

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

24.26.01 – Rules of Midwifery

Wednesday, November 12, 2025
9:30 a.m. (MT)

Attend via Microsoft Teams: Link
Meeting Number (Access Code): 269 319 693 616 9
Meeting password: ns9Xb3tH

Attend in person at:
Division of Occupational and Professional Licenses
EagleRock Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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 seeks to make final certain amendments to the fee table made through temporary rulemaking earlier this year published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 70-71. The rulemaking adjusts permit fees downwards to address the Board's cash balance, while simultaneously reducing costs for licensees.

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

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to make final certain temporary fee reductions.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not conducted because DOPL wanted to provide immediate relief to the regulated community by adopting a temporary rule that mirrors the fee reduction in this proposed rule. The Notice of Rulemaking – Adoption of Temporary Rule was published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 70-71. Any stakeholder input and all public comments submitted at the scheduled public hearing will be considered.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

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 November 26, 2025.

DATED this 17th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 24-2601-2501
(Only Those Sections With Amendments Are Shown.)

24.26.01 – RULES OF MIDWIFERY

400. FEES.
~~Unless otherwise provided for, all fees are n~~Non-refundable fees are as follows~~.~~:

APPLICATION	FEE ~~(Not to Exceed)~~
Initial Application	~~$200~~Not more than $90
Initial License	~~$800 (amount will be refunded if license not issued)~~Not more than $90
Renewal	~~$850 (amount will be refunded if license not renewed)~~Not more than $90
Reinstatement	~~$50~~Not more than $35, in addition to renewal fees.

~~(3-28-23)~~(____)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.31.01 – RULES OF THE IDAHO STATE BOARD OF DENTISTRY

DOCKET NO. 24-3101-2501

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This action is authorized pursuant to Section 67-2604, Idaho Code.

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

24.31.01 – Rules Of The Idaho Board Of Dentistry

Wednesday, November 12, 2025
9:30 a.m. (MT)

Attend via Microsoft Teams: Link
Meeting Number (Access Code): 269 319 693 616 9
Meeting password: ns9Xb3tH

Attend in person at:
Division of Occupational and Professional Licenses
EagleRock Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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 seeks to make final certain amendments to the fee table made through temporary rulemaking earlier this year published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 72-73. The rulemaking adds language to the fee table that allows the Board of Dentistry greater capability to reduce fees temporarily to address the Board's existing cash balances and to lower costs for licensees.

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

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to make final increased capability of the Board to temporarily reduce fees if necessary.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not conducted because DOPL wanted to provide immediate relief to the regulated community by adopting a temporary rule that mirrors the fee reduction in this proposed rule. The Notice of Rulemaking – Adoption of Temporary Rule was published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 72-73. Any stakeholder input and all public comments submitted at the scheduled public hearing will be considered.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126. 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 November 26, 2025.

DATED this 17th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 24-3101-2501
(Only Those Sections With Amendments Are Shown.)

24.31.01 – RULES OF THE IDAHO STATE BOARD OF DENTISTRY

400. FEES.

01. Application and License Fees. Fees are as follows:

License/Permit Type	Application Fee	License/Permit Fee
Dentist/Dental Specialist	Not more than $300	~~Active Status:~~ Not more than $375 ~~Inactive Status: $160~~
Dental Hygienist	Not more than $150	~~Active Status:~~ Not more than $175 ~~Inactive Status: $85~~
Dental Therapist	Not more than $200	~~Active Status:~~ Not more than $250 ~~Inactive Status: $125~~
Sedation Permit	Not more than $300	$300

~~(7-1-24)~~( )

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.34.01 – RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 24-3401-2501

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code.

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

24.34.01 – Rules Of The Idaho Board Of Nursing

Wednesday, November 12, 2025
9:30 a.m. (MT)

Attend via Microsoft Teams: Link
Meeting Number (Access Code): 269 319 693 616 9
Meeting password: ns9Xb3tH

Attend in person at:
Division of Occupational and Professional Licenses
EagleRock Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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 seeks to make final certain amendments to the fee table made through temporary rulemaking earlier this year published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 74-75. The rulemaking adds language to the fee table that allows the Board of Nursing greater capability to reduce fees temporarily to address the Board's existing cash balances and to lower costs for licensees.

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

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to make final increased capability of the Board to temporarily reduce fees if necessary.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not conducted because DOPL wanted to provide immediate relief to the regulated community by adopting a temporary rule that mirrors the fee reduction in this proposed rule. The Notice of Rulemaking – Adoption of Temporary Rule was published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 74-75. Any stakeholder input and all public comments submitted at the scheduled public hearing will be considered.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

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 November 26, 2025.

DATED this 17th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 24-3401-2501
(Only Those Sections With Amendments Are Shown.)

24.34.01 – RULES OF THE IDAHO BOARD OF NURSING

400. INITIAL LICENSE, RENEWAL AND REINSTATEMENT FEES.

01. Assessed Fees. Fees will be assessed for issuance, renewal of licensure or for reinstatement of a lapsed, disciplined, limited, or emeritus license. Fees are due at the time of submission. Any person submitting the renewal application and fee dated later than August 31 is considered delinquent, and the license lapsed and therefore invalid:

Initial Licensure, Renewal & Reinstatement Fees				
	Registered Nurse	**Practical Nurse**	**Advanced Practice Nurse**	**Medication Assistant - Certified**
Temporary License Fee	Not more than $25	Not more than $25	Not more than $25	
Initial Application Fee			Not more than $90	
License by Exam Fee	Not more than $90	Not more than $75	Not more than $90	
License by Endorsement	Not more than $110	Not more than $110		
License Renewal	Not more than $90	Not more than $90	Not more than $90	Not more than $35
Expiration Date	Aug 31-odd years	Aug 31-even years	Aug 31-odd years	Aug 31-even years

~~(3-28-23)~~( )

02. Reinstatement Fee. Nurses requesting reinstatement of a lapsed, disciplined, or restricted license, or reinstatement of an emeritus license to active status, will be assessed the ~~records verification and renewal fees~~ thirty-five dollar ($35) reinstatement fee provided for in Section 67-2614(9), Idaho Code, in addition to renewal fees. ~~(3-28-23)~~( )

~~**03. Other Fees**.~~

~~Records Verification Fee~~	~~$35~~

~~(3-28-23)~~

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.39.30 – RULES OF BUILDING SAFETY (BUILDING CODE RULES)

DOCKET NO. 24-3930-2501

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This action is authorized pursuant to Section 67-2604, Idaho Code.

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

24.39.30 – Rules Of Building Safety (Building Code Rules)

Wednesday, November 12, 2025
9:00 a.m. (MT)

Attend via Webex: Link
Meeting Number (Access Code): 2868 448 7497
Meeting password: ZnrnMr2ND42

Attend in person at:
Division of Occupational and Professional Licenses
EagleRock Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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 seeks to make final certain amendments to the permit fee table made through temporary rulemaking earlier this year published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Page 78-80. The rulemaking adjusts permit fees downwards to address the Board's cash balance, while simultaneously reducing costs for licensees.

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

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to make final certain temporary permitting fee reductions.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not conducted because DOPL wanted to provide immediate relief to the regulated community by adopting a temporary rule that mirrors the fee reduction in this proposed rule. The Notice of Rulemaking – Adoption of Temporary Rule was published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 78-80. Any stakeholder input and all public comments submitted at the scheduled public hearing will be considered.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

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 November 26, 2025.

DATED this 17th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 24-3930-2501
(Only Those Sections With Amendments Are Shown.)

24.39.30 – RULES OF BUILDING SAFETY (BUILDING CODE RULES)

500. PERMITS AND PLAN REVIEW.

01. Annual Permit. In lieu of an individual permit for each minor alteration to an already approved building, the Division may issue an annual permit upon application therefor to any state agency or state governmental organization regularly employing one (1) or more qualified trade persons in the building, structure or on the premises or campus owned or operated by the applicant for the permit. The agency to whom an annual permit is issued shall keep a detailed record of alterations made under such annual permit. The Division shall be allowed access to such records upon request or such records shall be filed with the Division as designated. The permit holder shall request inspections and make the work accessible for inspection as required by the adopted codes and herein. (7-1-24)

02. Plans Not Required. Plans are not required for group U occupancies of Type V conventional light-frame wood construction. (7-1-24)

03. Fees. (7-1-24)

a. Technical Service Fee. One hundred dollars ($100) per hour. (7-1-24)

b. Building Permit Fees. The determination of value or valuation will be made by the administrator and includes the total value of all construction work for which a permit is issued.

TABLE 1-A - BUILDING PERMIT FEES		
Total Valuation		**Fee**
$1 to $500	=	$~~23.50~~16.45
$501 to $2,000	=	$~~23.50~~16.45 for the first $500 plus $~~3.05~~2.14 for each additional $100, or fraction thereof, to and including $2,000
$2,001 to $25,000	=	$~~69.25~~48.48 for the first $2,000 plus $~~14~~9.80 for each additional $1,000, or fraction thereof, to and including $25,000
$25,001 to $50,000	=	$~~391.75~~274.23 for the first $25,000 plus $~~10.10~~7.07 for each additional $1,000, or fraction thereof, to and including $50,000
$50,001 to $100,000	=	$~~643.75~~450.63 for the first $50,000 plus $~~7~~4.90 for each additional $1,000, or fraction thereof, to and including $100,000
$100,001 to $500,000	=	$~~993.75~~695.63 for the first $100,000 plus $~~5.60~~3.92 for each additional $1,000, or fraction thereof, to and including $500,000
$500,001 to $1,000,000	=	$~~3,233.75~~2,263.63 for the first $500,000 plus $~~4.75~~3.33 for each additional $1,000, or fraction thereof, to and including $1,000,000
$1,000,001 to $5,000,000	=	$~~5,608.75~~3,926.13 for the first $1,000,000 plus $~~3.65~~2.56 for each additional $1,000, or fraction thereof, to and including $5,000,000
$5,000,001 to $10,000,000	=	$~~20,208.75~~14,146.13 for the first $5,000,000 plus $~~2.75~~1.93 for each additional $1,000, or fraction thereof, to and including $10,000,000
$10,000,001 and up	=	$~~33,958.75~~23,771.13 for the first $10,000,000 plus $~~2~~1.40 for each additional $1,000, or fraction thereof

~~(7-1-24)~~( )

c. Fees for Annual Permits. A fee for inspections performed on annual permits shall be charged at the rate of one hundred dollars ($100) per inspection. The Division shall bill the applicant for annual permits and failure of the applicant to pay the fee within sixty (60) days may result in cancellation of the annual permit. (7-1-24)

d. Plan Review Fees. Plan review fees shall be charged at an hourly rate of one hundred dollars ($100) per hour up to a maximum of sixty-five percent (65%) of the calculated building permit fee with a minimum required fee of forty percent (40%) of the calculated building permit fee. All requests for plan review services shall be accompanied by a payment in the amount of at least forty percent (40%) of the calculated building permit fee. Upon completion of the plan review, any additional fees, above the minimum required, are due to the Division by the requesting party. (7-1-24)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.39.31 – RULES FOR FACTORY BUILT STRUCTURES

DOCKET NO. 24-3931-2501

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code.

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

24.39.31 – Rules For Factory Built Structures

Wednesday, November 12, 2025
9:00 a.m. (MT)

Attend via Webex: Link
Meeting Number (Access Code): 2868 448 7497
Meeting password: ZnrnMr2ND42

Attend in person at:
Division of Occupational and Professional Licenses
EagleRock Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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 seeks to make final certain amendments to the permit fee table made through temporary rulemaking earlier this year published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 81-82. The rulemaking adjusts permit fees downwards to address the Board's cash balance, while simultaneously reducing costs for licensees.

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

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to make final certain temporary permitting fee reductions.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not conducted because DOPL wanted to provide immediate relief to the regulated community by adopting a temporary rule that mirrors the fee reduction in this proposed rule. The Notice of Rulemaking – Adoption of Temporary Rule was published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 81-84. Any stakeholder input and all public comments submitted at the scheduled public hearing will be considered.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

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 November 26, 2025.

DATED this 17th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 24-3931-2501
(Only Those Sections With Amendments Are Shown.)

500. PERMITS, PLAN REVIEWS, AND INSPECTIONS.

01. Modular Building Permit Fees. Permits must be obtained from the Division prior to the construction of structures governed by 39-4303, Idaho Code. Other than as specified in this section, the permit fee schedule for Modular Buildings is as provided in Table 1-A plus ninety dollars ($90) and two and one-half percent (2.5%) of the plumbing, electrical, and HVAC installation costs. The determination of value or valuation is based on the total value of all construction work for which a permit is issued.

TABLE 1-A – MODULAR BUILDING PERMIT FEES

TOTAL VALUATION		FEE
$1 to $500	=	$~~23.50~~18.80
$501 to $2,000	=	$~~23.50~~18.80 for the first $500 plus $~~3.05~~2.44 for each additional $100, or fraction thereof, to and including $2,000
$2,001 to $25,000	=	$~~69.25~~55.40 for the first $2,000 plus $~~14~~11.20 for each additional $1,000, or fraction thereof, to and including $25,000
$25,001 to $50,000	=	$~~391.75~~313.40 for the first $25,000 plus $~~10.10~~8.09 for each additional $1,000, or fraction thereof, to and including $50,000
$50,001 to $100,000	=	$~~643.75~~515 for the first $50,000 plus $~~7~~5.60 for each additional $1,000, or fraction thereof, to and including $100,000
$100,001 to $500,000	=	$~~993.75~~795 for the first $100,000 plus $~~5.60~~4.48 for each additional $1,000, or fraction thereof, to and including $500,000

TABLE 1-A – MODULAR BUILDING PERMIT FEES		
TOTAL VALUATION		FEE
$500,001 to $1,000,000	=	$~~3,233.75~~2,587 for the first $500,000 plus $~~4.75~~3.80 for each additional $1,000, or fraction thereof, to and including $1,000,000
$1,000,001and up	=	$~~5,608.75~~4,487 for the first $1,000,000 plus $~~3.65~~2.92 for each additional $1,000, or fraction thereof

~~(7-1-24)~~( )

02. Modular Plan Review. The Modular Building fee includes an additional amount equal to sixty-five percent (65%) of the permit fee calculated in accordance with Table 1-A. A fee of sixty-five dollars ($65) per hour applies to additional plan review required by changes, additions, or revisions to plans. (7-1-24)

03. Manufactured/Mobile Home Installation Permit Fees. Permits must be obtained from the Division prior to the site installation governed by 44-2202, and 39-4004, Idaho Code in accordance with the following schedule: (7-1-24)

a. Single Section Unit. The permit fee is one hundred ~~fifty~~ twenty dollars ($~~150~~120). ~~(7-1-24)~~( )

b. Double Section Unit. The permit fee is ~~two~~ one hundred sixty dollars ($~~200~~160). ~~(7-1-24)~~( )

c. More Than Two Sections. The permit fee for a home consisting of more than two (2) sections is two hundred ~~fifty~~ dollars ($~~250~~200). ~~(7-1-24)~~( )

04. In-Plant Inspection Agency Fees. In-plant inspection fees for manufactured homes produced by Idaho Manufactures as per 39-4003A and 39-4004 of Idaho Code is set at forty-five dollars ($45) per floor. (7-1-24)

05. Inspections at Manufacturing Plants. The Division conducts inspections at the manufacturing plant to determine compliance with codes adopted by Title 39, Chapters 40 and 41, Idaho Code, and Title 54, Chapters 10, 26, and 50, Idaho Code. (7-1-24)

06. Manufactured Home Site Installation Inspections. Installation permits must be obtained from the Division for installations in areas where there is no approved local program, or from a city or county that has by ordinance adopted building codes pursuant to Section 39-4116, Idaho Code, and whose installation program has been approved by the Division. All installations must be inspected and approved by the authority having jurisdiction before the manufactured home is occupied. (7-1-24)

a. Installation inspections shall be conducted in accordance with the Idaho Manufactured Home Installation Standard or the Design Approval Primary Inspection Agency of the manufactured home. (7-1-24)

07. Modular Site Installation Inspection. In order to complete the installation of an Idaho approved Modular Building, approval and inspection of the installation by the enforcement agency having jurisdiction over the site location is required. (7-1-24)

08. Qualifications of Inspectors. All inspectors must be properly certified for the type of inspection being conducted. The Factory Built Structures Board recognizes certifications granted through the National Certification Program Construction Code Inspector program (NCPCCI), the National Inspection Testing Certification program (NITC), the International Association of Electrical Inspectors (IAEI), and the International Code Council (ICC). (7-1-24)

09. Minimum Training Requirements for Inspectors. All manufactured home installation inspectors must complete eight (8) hours of training or instruction germane to the profession. (7-1-24)

10. Rights and Limitations of Local Enforcement Agencies for Modular Buildings. (7-1-24)

a. A local enforcement agency has the right to require a complete set of plans and specifications approved by the Division for each Modular Building to be installed within its jurisdiction, to require that all permits be obtained before delivery of any unit. (7-1-24)

b. A local enforcement agency does not have the right to: open for inspection any Modular Building or component bearing an Insignia to determine compliance with any codes or ordinances; require by ordinance or otherwise that Modular Buildings meet any requirements not equally applicable to on-site construction; or to charge permit or plan review fees for any portion of the structure prefabricated or assembled at a place other than the Building Site. (7-1-24)

11. Division Approval. A city or county that has by ordinance adopted a building code pursuant to Section 39-4116, Idaho Code, is eligible to participate in the inspection of manufactured and mobile homes. Such local installation inspection program must be approved by the Division to provide inspection services if the following minimum criteria is met: (7-1-24)

a. Inspections are conducted by the city or county employing inspectors holding a valid certification as residential building inspector from the International Code Council; (7-1-24)

b. Inspectors attended training sessions provided or approved by the Division and receive a certificate evidencing successful completion thereof. (7-1-24)

c. Voluntary Withdrawal. A city or county may voluntarily withdraw from participation in the program to inspect manufactured homes upon providing to the Administrator of the Division thirty (30) days written notice of its intention to do so. (7-1-24)

d. Quality Assurance. Any inspected installation is subject to quality assurance reviews by Division of Occupational and Professional Licenses. Findings made by the Division pursuant to such reviews will be forwarded to the inspection authority having jurisdiction. (7-1-24)

i. All inspectors and approved programs are subject to review. (7-1-24)

12. Modular Insignia and Serial Number. (7-1-24)

a. Assigned Insignia are not transferable and are void when not affixed as assigned. (7-1-24)

b. Each Modular Building must bear a legible identifying serial number. Each section of a multiple Modular Building must have the same identifying serial number followed by a numerical sequence identifier or a letter suffix, or both. (7-1-24)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.39.50 – RULES OF THE PUBLIC WORKS CONTRACTORS LICENSE BOARD

DOCKET NO. 24-3950-2501

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code.

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

24.39.50 – Rules Of The Public Works Contractors License Board

Wednesday, November 12, 2025
9:00 a.m. (MT)

Attend via Webex: Link
Meeting Number (Access Code): 2868 448 7497
Meeting password: ZnrnMr2ND42

Attend in person at:
Division of Occupational and Professional Licenses
EagleRock Room, Chinden Campus
11341 W. Chinden Blvd., Bldg. 4
Boise, ID 83714

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 seeks to make final certain amendments to the fee table made through temporary rulemaking earlier this year published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 86-87. The rulemaking adds language to the fee table that allows the Board greater capability to reduce fees temporarily to address the Board's existing cash balances and to lower costs for licensees.

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

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to make final increased capability of the Board to temporarily reduce fees if necessary.

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:

No fiscal impact on the state general fund will occur as a result of these changes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1) and 67-5221(1)(j), Idaho Code, negotiated rulemaking was not conducted because DOPL wanted to provide immediate relief to the regulated community by adopting a temporary rule that mirrors the fee reduction in this proposed rule. The Notice of Rulemaking – Adoption of Temporary Rule was published in the January 1, 2025 Idaho Administrative Bulletin, Vol. 25-1, Pages 86-87. Any stakeholder input and all public comments submitted at the scheduled public hearing will be considered.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126. 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 November 26, 2025.

DATED this 17th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 24-3950-2501
(Only Those Sections With Amendments Are Shown.)

400. FEES.

01. Public Works Contractor.

License Class	Initial Fee (Not to exceed)	Renewal Fee (Not to exceed)
Unlimited	$550	$440
AAA	$450	$360
AA	$350	$280
A	$250	$160
B	$150	$120
CC	$125	$100
C	$100	$80
D	$50	$40

~~(7-1-24)~~(____)

02. Construction Manager:

License Activity	Fee (Not to exceed)
Initial Licensing	$200

License Activity	Fee (Not to exceed)
License Renewal	$200
Inactive License	$50
License Reinstatement	$200
Certificate of Authority	$100

~~(7-1-24)~~(____)

IDAPA 34 – SECRETARY OF STATE

34.03.01 – RULES IMPLEMENTING THE SUNSHINE LAW

DOCKET NO. 34-0301-2501

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2026 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective on July 1 following the Second Regular Session of the Sixty-eighth Idaho Legislature, unless the concurrent resolution states a different effective date.

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 74-710(2)(f) 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:

This rule will remove rules related to lobbyists following the passage of House Bill 398. The underlying code requiring annual reporting, Section 67-6619, Idaho Code, was repealed. The registration form and fee, as well as the requirements for monthly reporting, were codified in the new Chapter 7, Title 74, Idaho Code. No comments were submitted in response to the June 4, 2025, bulletin publication of the proposed rule.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the June 4, 2025, Idaho Administrative Bulletin, Vol. 25-6, pages 352-354.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, a pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: 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.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Robert McQuade at (208) 334-2300.

DATED this 15th day of September, 2025.

Robert H. McQuade, Jr.
Assistant Chief Deputy
Idaho Secretary of State's Office
700 W. Jefferson St., Room E205
Boise, ID 83702
P.O. Box 83720
Boise, ID 83720-0080
(208) 334-2300

Sections Affected Index

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

18.04.15 – Rules Governing Short-Term Health Insurance Coverage

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24.26.01 – Rules of Midwifery

Docket No. 24-2601-2501

24.31.01 – Rules of the Idaho State Board of Dentistry

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24.34.01 – Rules of the Idaho Board of Nursing

Docket No. 24-3401-2501

24.39.30 – Rules of Building Safety (Building Code Rules)

Docket No. 24-3930-2501

24.39.31 – Rules for Factory Built Structures

Docket No. 24-3931-2501

24.39.50 – Rules of the Public Works Contractors License Board

Docket No. 24-3950-2501

LEGAL NOTICE

Summary of Proposed Rulemakings

PUBLIC NOTICE OF INTENT
TO PROPOSE OR PROMULGATE NEW OR CHANGED AGENCY RULES

The following agencies of the state of Idaho have published the complete text and all required information concerning their intent to change or make new the following rules in the latest publication of the state Administrative Bulletin.

The proposed rule public hearing request deadline is November 19, 2025, unless otherwise posted.
The proposed rule written comment submission deadline is November 26, 2025, unless otherwise posted.
(Temp & Prop) indicates the rulemaking is both Temporary and Proposed.
(*PH) indicates that a public hearing has been scheduled.

IDAPA 02 – DEPARTMENT OF AGRICULTURE
PO Box 7249, Boise, ID 83707

02-0609-2503, Rules Governing Invasive Species and Noxious Weeds. (*PH) Proposed changes remove prohibition of watercraft from the Quagga mussel treatment area on the Snake River and add Golden mussel to the Emergency Detection Rapid Response Invasive Species list to ensure adequate prevention and response efforts in Idaho.

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES
11341 W Chinden Blvd, Bldg. 4, Boise, ID 83714

24-2601-2501, Rules of Midwifery. (*PH) Rulemaking adjusts permit fees downwards to address the Board's cash balance, while simultaneously reducing costs for licensees.
24-3101-2501, Rules of the Idaho State Board of Dentistry. (*PH) Language is added that allows the Board of Dentistry greater capability to reduce fees temporarily to address the Board's existing cash balances and to lower costs for licensees.
24-3401-2501, Rules of the Idaho Board of Nursing. (*PH) Amendments allow the Board of Nursing greater capability to reduce fees temporarily to address the Board's existing cash balances and to lower costs for licensees.
24-3930-2501, Rules of Building Safety (Building Code Rules). (*PH) Proposed edits decrease permit fees to achieve Board solvency, while simultaneously reducing costs for licensees.
24-3931-2501, Rules for Factory Built Structures. (*PH) To address the Board's cash balance, this rulemaking lowers permit fees while simultaneously reducing costs for licensees.
24-3950-2501, Rules of the Public Works Contractors License Board. (*PH) Language is added that allows the Board greater capability to reduce fees temporarily to address the Board's existing cash balances and to lower costs for licensees.

EXECUTIVE ORDERS OF THE GOVERNOR

2025-06, Creation of the Idaho Advanced Nuclear Energy Task Force
2025-07, Deferred Compensation Program for Employees of the State of Idaho
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02-0609-2502, Rules Governing Invasive Species and Noxious Weeds

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE
18-0415-2501, Rules Governing Short-Term Health Insurance Coverage

Please refer to the Idaho Administrative Bulletin **November 5, 2025, Volume 25-11**, for the notices and text of all rulemakings, proclamations, negotiated rulemaking and public hearing information and schedules, executive orders of the Governor, and agency contact information.

***Electronic issues of the Idaho Administrative Bulletin can be viewed at* www.adminrules.idaho.gov/**

Office of the Administrative Rules Coordinator, Division of Financial Management
P.O. Box 83720, Boise, ID 83720-0032
Phone: 208-334-3900; Email: **adminrules@dfm.idaho.gov**

CUMULATIVE RULEMAKING INDEX
OF IDAHO ADMINISTRATIVE RULES

Office of the Administrative Rules Coordinator
Division of Financial Management
Office of the Governor

July 1, 1993 – Present

CUMULATIVE RULEMAKING INDEX OF IDAHO ADMINISTRATIVE RULES

This index provides a history of all agency rulemakings beginning with the first Administrative Bulletin in July 1993 to the most recent Bulletin publication. It tracks all rulemaking activities on each chapter of rules by the rulemaking docket numbers and includes negotiated, temporary, proposed, pending and final rules, public hearing notices, vacated rulemaking notices, notice of legislative actions taken on rules, and executive orders of the Governor.

ABRIDGED RULEMAKING INDEX
OF IDAHO ADMINISTRATIVE RULES

(Index of Current and Active Rulemakings)

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Division of Financial Management

April 4, 2025 – November 5, 2025

(PLR 2026) – Final Effective Date Is Pending Legislative Review in 2026
(eff. date)L – Denotes Adoption by Legislative Action
(eff. date)T – Temporary Rule Effective Date
SCR # – denotes the number of a Senate Concurrent Resolution (Legislative Action)
HCR # – denotes the number of a House Concurrent Resolution (Legislative Action)

(This Abridged Index includes all active rulemakings.)

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02.01.05, Rules Governing Certificates of Free Sale

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