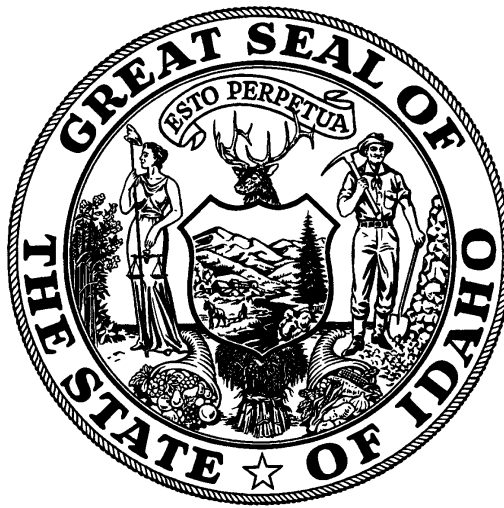


PENDING RULES

COMMITTEE RULES

REVIEW BOOK

Submitted for Review Before
Senate Health & Welfare Committee
68th Idaho Legislature
Second Regular Session – 2026



Prepared by:

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

January 2026

SENATE HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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**IDAPA 15 – OFFICE OF THE GOVERNOR
IDAHO COMMISSION ON AGING**

15.01.01 – RULES GOVERNING SENIOR SERVICES AND OLDER AMERICANS ACT PROGRAMS

DOCKET NO. 15-0101-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 67-5003](#), Idaho Code.

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

Under [Executive Order 2020-01: Zero-Based Regulation](#), the Agency is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government.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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

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 October 1, 2025, Idaho Administrative Bulletin, [Vol. 25-10, pages 252–257](#).

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: NA.

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

There is no fiscal impact as a result of this rulemaking.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Bettina Briscoe, 208-577-2858.

DATED this 4th day of November, 2025.

Judy Taylor, Director
Idaho Commission on Aging
6305 Overland Rd., Suite 110
Boise, ID 83709
Phone: 208-334-3833
Email: ICOA@aging.idaho.gov
Website: <https://aging.idaho.gov/>

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

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

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

Wednesday, October 8, 2025 10:00 a.m. (MT)
To attend in person: Idaho Commission on Aging 6305 W. Overland Road Suite 110 Boise, Idaho 83709 To attend via Microsoft Teams: Join the meeting now Meeting ID: 234 953 043 154 3 Passcode: Jp3b9aR9 Dial in by phone +1 208-985-2810,,52181951# United States, Boise Find a local number Phone conference ID: 521 819 51#

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

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

These rules are being presented for authorization as part of the Idaho Commission on Aging's plan to review each rule every 5 years under [Executive Order 2020-01, Zero-Based Regulation](#). The Commission seeks to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify language. The Idaho Commission on Aging intends to carefully consider all changes presented by the public and may propose certain changes so long as they are consistent with the rules' statutory authority and the Governor's Executive Order.

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

There are no fees associated with 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 resulting from this rulemaking:

There is no fiscal impact as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to [Section 67-5220\(1\)](#), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the July 2nd, 2025, Vol. 25-7, p 48-49, Idaho Administrative Bulletin.

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:

There are no documents incorporated by reference associated with this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Bettina Briscoe, 208-577-2858.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2025.

DATED this 15th day of September, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 15-0101-2501

15.01.01 – RULES GOVERNING SENIOR SERVICES AND OLDER AMERICANS ACT PROGRAMS

000. LEGAL AUTHORITY.

~~Under authority of~~ [Section 67-5003](#), Idaho Code, ~~the Idaho Commission on Aging adopts the following rules.~~
(3-31-22)()

001. ~~TITLE AND~~ SCOPE.

~~01. Title.~~ These rules are titled IDAPA 15.01.01, “Rules Governing Senior Services and Older Americans Act Programs.” (3-31-22)

~~02. Scope.~~ These rules constitute minimum requirements for aging services funded under authority of [Sections 67-5005 through 5008](#) [Title 67 Chapter 50](#), Idaho Code, and the [Older Americans Act of 1965 as Amended \(OAA\)](#), and ~~include a list of common terms and definitions~~ [45 CFR Part 1321](#) related to Idaho’s aging programs ~~and services.~~
(3-31-22)()

002. -- 009. (RESERVED)

010. DEFINITIONS.

~~01. Act.~~ The Idaho Senior Services Act. Programs and services established in [Sections 67-5001 through 67-5011](#), Idaho Code. (3-31-22)

~~02. Aging Network.~~ The ICOA, the AAAs, Focal Points and other providers of direct service to older individuals. (3-31-22)

~~03. Area Agency on Aging (AAA).~~ Separate organizational unit within a unit of general purpose local government or public or private non-profit agency or organization agency that functions only for purposes of serving

~~as the area agency on aging that plans, develops, and implements services for older persons within a specified geographic area.~~ (3-31-22)

041. Assessment. An instrument utilizing uniform criteria to assess eligibility. (3-31-22)

~~**05. Caregiver.** An adult family member or another individual, who is an “informal” provider of in-home and community care to an older individual. “Informal” means that the care is not provided as part of a public or private formal service program.~~ (3-31-22)

062. Client. Person who has met service eligibility requirements ~~addressed in this chapter.~~ (3-31-22)()

03. Cognitive Limitations. The inability to perform one (1) or more of the following eight (8) instrumental activities of daily living without personal assistance, or stand-by assistance, supervision or cues: preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, and transportation ability (transportation ability refers to the individual's ability to make use of available transportation without assistance). ()

074. Cost Sharing Payment. An established payment required from ~~individuals~~ clients receiving services under this chapter. The cost sharing payment varies by regulation and according to client's current annual household or individual income. (3-31-22)()

08. Department. Idaho Department of Health and Welfare. (3-31-22)

05. Eligibility. Someone who may receive services in alignment with federal and state law, operational guidance, and budget constraints. ()

096. Focal Point. A facility ~~established~~ identified to ~~encourage~~ facilitate the maximum collocation and coordination of services for older individuals. (3-31-22)()

~~**107. Formal Supports.** Services provided to clients by a formally organized entity, including, but not limited to, Medicaid HCBS.~~ (3-31-22)

08. Functional Limitation. The inability to perform one (1) or more of the following six (6) activities of daily living without personal assistance, stand-by assistance, supervision or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking. ()

~~**109. Household.** For sliding fee purposes, a “household” includes a client and any other person permanently resident in the same dwelling who share accommodations and expenses with the client.~~ (3-31-22)

12. ICOA. Idaho Commission on Aging. (3-31-22)

13. ICOA Program Manual. Operational guidance for services and programs. (3-31-22)

14. Impairment in Activities of Daily Living (ADL). ~~The inability to perform one or more of the following six activities of daily living without personal assistance, stand-by assistance, supervision or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking.~~ (3-31-22)

15. Impairment in Instrumental Activities of Daily Living (IADL). ~~The inability to perform one or more of the following eight instrumental activities of daily living without personal assistance, or stand-by assistance, supervision or cues: preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, and transportation ability (transportation ability refers to the individual's ability to make use of available transportation without assistance).~~ (3-31-22)

160. Informal Supports. Supports provided by church, family, friends, and neighbors, usually at no cost to the client. (3-31-22)

171. ~~Medicaid-HCBS Services, Programs and S~~services approved under ~~the~~ Medicaid ~~Waiver~~ for the aged and disabled. (3-31-22)()

182. ~~Older Americans Act~~ as Amended (OAA). Federal law which authorizes funding to states to provide home and community-based services for older persons. (3-31-22)()

19. ~~Program.~~ The Idaho Senior Services and Older Americans Act programs as administered by the ICOA. (3-31-22)

20. ~~Program Regulations.~~ Applicable Federal statutes and regulations, the act, and these rules. (3-31-22)

213. ~~Provider.~~ An Area Agency on Aging (AAA) or a person or entity capable of providing services to clients under a formal contractual arrangement including duly authorized agents and employees. (3-31-22)()

22. ~~Services.~~ Long-term services and supports that assist clients to remain in their home and community including but not limited to: Transportation, congregate meals, in-home services, adult day care and information and assistance. (3-31-22)

011. DEMONSTRATION PROJECTS.

The Administrator has authority to operate demonstration projects under the authority of section 67-5010, Idaho Code, which may be exempt from these rules at the Administrator's discretion. (3-31-22)

012. PROGRAM PURPOSE.

The Idaho Senior Services Act and Older Americans Act Services are designed to provide older individuals with the assistance they need to compensate for functional or cognitive limitations with the goal of living safe, dignified, and healthy lives within the community of their choice. (3-31-22)

011. – 012. (RESERVED)

013. PROGRAM POLICY.

01. Idaho Commission On Aging (ICOA) Program Manual. ICOA program manual includes but not limited to the published operations manual, planning manual, policies and procedures, standardized forms and assessments, review toolkits, and any other official ICOA guidance. The manual is developed, modified, and updated with input from the appropriate stakeholder groups and approved by the Administrator. At the Administrator's discretion, the manual may be modified to adhere to state or federal law, ~~or~~ regulations, or best practices. (3-31-22)()

02. ~~Contracts.~~ The ICOA may contract with Providers to deliver home and community-based services in accordance with the regulations. (3-31-22)

032. ~~Home and Community Based Programs and Services.~~ Programs and Sservices offered by ICOA may include, but are not limited to: (3-31-22)()

a. ~~Adult Day Care.~~ Personal care for clients in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care/adult day health typically include social and recreational activities, training, counseling, and services such as rehabilitation, medications assistance and home health aide services for adult day health. (3-31-22)()

b. ~~Case Management.~~ Case management is a service provided to clients, at the direction of the individual or a family member of the individual, to assess the needs of the person and to arrange, coordinate, and monitor an optimum package of services to meet those needs. Activities of case management include: comprehensive assessment of the individual; development and implementation of a service plan with the individual to mobilize formal and informal resources and services; coordination and monitoring of formal and informal service delivery; and periodic reassessment. (3-31-22)()

- c.** Chore Services. ~~Providing assistance to clients who have functional limitations that prohibit them from performing tasks such as routine yard work, sidewalk maintenance, heavy cleaning, or minor household maintenance.~~ (3-31-22)()
- d.** Congregate Meals. ~~A meal provided to an eligible individual in a congregate or group setting. The meal served must meet program requirements.~~ (3-31-22)()
- e.** Health Promotion and Disease Prevention. ~~Services that include health screenings and assessments; organized physical fitness activities; evidence-based health promotion programs; medication management; home injury control services; and/or information, education, and prevention strategies for chronic disease and other health conditions that would reduce the length or quality of life of the person sixty (60) or older.~~ (3-31-22)()
- f.** Home-Delivered Meals. ~~Meals delivered to clients in private homes.~~ (3-31-22)()
- g.** Home Modification. ()
- h.** Homemaker Service. ~~Assistance with housekeeping, meal planning and preparation, essential shopping and personal errands, banking and bill paying, medication management, and, with restrictions, bathing and washing hair.~~ (3-31-22)()
- i.** Information and Assistance Services. ~~Provides current information about services available within the community, conducts intake and assessment, determines the appropriate available service, and makes a referral and to the extent practicable, establishes adequate follow-up procedures.~~ (3-31-22)()
- j.** Legal Assistance. ~~Advice, counseling, or representation by an attorney or by a paralegal under the supervision of an attorney.~~ (3-31-22)()
- k.** National Family Caregiver Program. that may include: (3-31-22)()
- i.** Counseling. ~~Assist caregivers in making decisions and solving problems relating to their caregiver roles. This includes counseling to individuals, support groups, and caregiver training (of individual caregivers and families).~~ (3-31-22)()
- ii.** Respite Care. ~~Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers.~~ (3-31-22)()
- iii.** Supplemental ~~s~~Services. ~~Services provided on a limited basis to complement the care provided by caregivers. Examples of supplemental services include, but are not limited to, home modifications, assistive technologies, emergency response systems, and incontinence supplies.~~ (3-31-22)()
- iv.** Information Services. ~~A service for caregivers that provides the public and individuals with information on resources and services available to the individuals within their communities.~~ (3-31-22)()
- v.** Access Assistance. ~~A service that assists caregivers in obtaining access to the services and resources that are available within their communities. To the maximum extent practicable, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures.~~ (3-31-22)()
- l.** Outreach Services. ~~A service which actively seeks out older individuals with greatest social and economic needs with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.~~ (3-31-22)()
- m.** Transportation Services. ~~Services designed to transport clients to and from community facilities/ resources for the purposes of applying for and receiving services, reducing isolation, or otherwise promoting independence.~~ (3-31-22)()
- n.** Respite. ~~Short-term, intermittent relief provided to caregivers of an ADL or IADL impaired care~~

recipient- (3-31-22)()

014. ~~PROGRAM ELIGIBILITY.~~(RESERVED)

~~Individuals are eligible for specific Services as established by the Older Americans Act and Idaho Senior Services Act.~~ (3-31-22)

015. SERVICE PRIORITY.

~~Highest priority is given to clients in immediate jeopardy then those with the greatest degree of ADL or IADL deficits and who are lacking formal and informal supports other than a caregiver. Caregiver services are prioritized by the Administrator in accordance with the Program Regulations. Services are prioritized as described in ICOA program guidance and the accepted area agency on aging (AAA) local plans. Exceptions may be made for clients in immediate jeopardy or a waiver approved by the Administrator. During declared emergencies alternative criteria may be used.~~ (3-31-22)()

016. SERVICE LIMITATIONS AND EXCEPTIONS.

01. Cost Sharing Payments. Payments ~~are~~ may be required based on the sliding fee scale established by the Administrator in accordance with the ~~P~~program ~~R~~regulations. (3-31-22)()

02. Service. Eligibility, denial, or termination are determined through the applicable ICOA Assessment. (3-31-22)

03. Medicaid Home and Community Based Services (HCBS). Clients or individuals determined by the ~~Idaho~~ Department ~~of Health and Welfare~~ to be eligible for Medicaid or Medicaid HCBS, are not eligible for ~~S~~services unless the ~~S~~services are determined by the ~~P~~provider to be needed on an interim, emergency basis until Medicaid or Medicaid HCBS is initiated. (3-31-22)()

017. -- 999. (RESERVED)

**IDAPA 15 – OFFICE OF THE GOVERNOR
IDAHO COMMISSION ON AGING**

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

DOCKET NO. 15-0120-2501 (ZBR CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 67-5003](#), Idaho Code.

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

Under [Executive Order 2020-01: Zero-Based Regulation](#), the Agency 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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

As a part of the negotiated rulemaking process, the Commission determined that these rules are duplicative of federal law and contractual terms with the Area Agencies on Aging (AAA) and therefore, can be repealed.

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 October 1, 2025, Idaho Administrative Bulletin, [Vol. 25-10, page 258](#).

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: NA.

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

There is no fiscal impact as a result of this rulemaking.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Bettina Briscoe, 208-577-2858.

DATED this 19th day of November, 2025.

Judy Taylor, Director
Idaho Commission on Aging
6305 Overland Rd., Suite 110
Boise, ID 83709
Phone: 208-334-3833
Email: ICOA@aging.idaho.gov
Website: <https://aging.idaho.gov/>

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2025.

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

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

As a part of the negotiated rulemaking process, the Commission determined that these rules are duplicative of federal law and contractual terms with the Area Agencies on Aging (AAA) and therefore, can be repealed.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees associated with 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 resulting from this rulemaking: There is no fiscal impact due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to [Section 67-5220\(1\)](#), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the July 2nd, 2025, [Vol. 25-7, p 52-53](#), Idaho Administrative Bulletin.

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: There are no documents incorporated by reference associated with this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Bettina Briscoe, 208-577-2858.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2025.

DATED this 15th day of September, 2025.

IDAPA 15.01.20 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY

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

15.02.30 – BUSINESS ENTERPRISE PROGRAM

DOCKET NO. 15-0230-2401 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 67-5407(c)(e) and 67-5408, Idaho Code, and 34 CFR 395.3(a)(1).

DESCRIPTIVE SUMMARY: Under Executive Order 2020-01, Zero Based Regulations, the Idaho Commission for the Blind and Visually Impaired is striving to prevent non-compliance with federal regulations governing the Business Enterprise Program, the accumulation of ineffective and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the pending rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. Additionally, the Rehabilitation Services Administration of the United States Department of Education approved the pending rule as required by federal law.

After collaborating with stakeholders and the Rehabilitation Services Administration of the United States Department of Education, the Commission has adopted a Pending Rule that differs from the Proposed Rule. The following is a summary of the substantive differences between the Proposed Rule and the Pending Rule:

- 110.01 – Active Participation. This definition was added to explain a vital dynamic between the BEP Vendors and ICBVI as the State Licensing Agency (SLA).
- 010.07 – IBMC. The content of this definition was changed to clearly specify the structure and purpose of this group.
- 010.14 – Permit. Renumbered to 010.09. Permit. This section was removed in the proposed rule but returned to the pending rule to maintain continuity.
- 030.03 – Reactivation. We clarified that specific reactivation requirements are now documented in internal controls so there is a definitive process for all parties to follow.
- 031.02.d. – General Rights and Responsibilities. The text of this paragraph was removed as there are federal protocols in place, and to reduce confusion over equipment ownership. A new paragraph unrelated to the previous text is now listed under 031.02(d).
- 031.02.d. – General Rights and Responsibilities. A new paragraph was added to indicate which jurisdiction governs a particular dispute.
- 040.01.d. – Grounds for License Termination relocated to 040.02(d) Grounds for OA Termination. This section was relocated to this placement as it is more appropriate in terms of the termination of an Operating Agreement. Licenses do not expire per federal regulations and termination due to medical reasons could be discriminatory. Furthermore, a license could simply become inactive and there is a process for reactivation.
- 040.04.b. – Grounds for OA Suspension. Clarifying language was added to indicate that the Vendor has the right to respond to any accusation prior to the Supervisor making a determination about the facility.
- 040.11 – Improvement Plan. This section now reflects that improvement plans can be collaborative and not solely used disciplinarily.
- 050.02 – Qualification of Bidders. Prohibitions on license probation and suspension were removed in the proposed rule but returned to the pending rule to maintain standards of quality.
- 071 – Maintenance and Replacement of Equipment. This section was rephrased to clarify that all maintenance and repair requests much go through the SLA.

- 160 – Idaho Blind Merchants Committee. A statement was added to specify when IBMC elections occur and indicate term length is two years.
- 160.01 – Active Participation. We removed this subsection in the pending rule because it is explained in the definition of Active Participation, and the amended definition of IBMC makes this redundant. See 110.07. IBMC.
- 180 – Administrative Review. This section and all references therein have been removed. RSA stipulated that this process must be entirely voluntary for the Vendor or Blind Licensee in order for the SLA to remain federally compliant. The current language of this rule also undermines the Vendor's rights to an Evidentiary Hearing and Arbitration, IDAPA 15.02.30.190, and 200, and creates a potential conflict of interest for the state.
- 189 – Informal Dispute Resolution. A new section was added to provide a dispute process for individuals going through the BEP Curriculum and Provisional Licensees.
- 190.01 – Request. This section was rephrased to clarify that requesting an evidentiary hearing is done by filing a complaint rather than a separate request being made after a complaint was filed.
- 190.04 – Hearing Officer. We were required to more clearly specify how this position is filled and by whom to avoid potential conflicts of interest, ensure the Vendor's rights, and maintain consistency in these proceedings.

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 November 6, 2024, Idaho Administrative Bulletin, [Vol. 24-11, pages 37-54](#).

FEE SUMMARY: There is no fee or charge imposed or increased in this rulemaking.

FISCAL IMPACT: N/A.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Arianah Ruzovich (208)-639-8390, email arianah.ruzovich@icbvi.idaho.gov.

DATED this 12th day of December, 2025.

Arianah Ruzovich
Business Enterprise Program Specialist
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
Boise, ID 83702
(208)-639-8390

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 67-5407(c)(e) and 67-5408 Idaho Code.

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

15.02.30 – Business Enterprise Program
Thursday, November 14, 2024 2:00 p.m. to 3:00 p.m. (MST)
In-person participation is available at: Idaho Commission for the Blind and Visually Impaired 341 W. Washington, 2nd Floor Conference Room Boise, ID 83702
Web meeting link: Join the meeting now
Meeting ID: 226 014 363 239 Passcode: AkhL7s
Download Teams Join on the web

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:

Under [Executive Order 2020-01, Zero-Based Regulation](#), the Idaho Commission for the Blind and Visually Impaired is striving to prevent the accumulation ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: There is no fee or charge imposed or increased associated with this rulemaking.

FISCAL IMPACT: N/A.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the September 4, 2024 Idaho Administrative Bulletin, [Vol.24-9 page 50](#).

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:

- The Business Enterprise Program is administered under the following federal and state statutes:
- 20 U.S.C Ch. 6A Randolph-Sheppard Act
- 34 CFR 395
- Section 67-5402, 67-5411, 67-5909, 67-6901, 67-6902, 67-6903, 67-6904, 67-6905 Idaho Code

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mike Walsh at 208-334-3220.

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 27, 2024.

DATED this 17th day of October, 2024.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 15-0230-2401

Italicized red text that is double underscored indicates amendments to the proposed text as adopted in the pending rule.

15.02.30 – BUSINESS ENTERPRISE PROGRAM

000. LEGAL AUTHORITY.

~~The Idaho Legislature has designated the Commission for the Blind and Visually Impaired as the sole licensing agency under the provisions of the Randolph-Sheppard vending stand act pursuant to Section 67-5411, Idaho Code, and has given to the Board of the Idaho Commission for the Blind and Visually Impaired the legislative power to promulgate rules by the provisions of Section 67-5407(e), Idaho Code.~~ The Idaho Legislature, as approved by the U.S. Secretary of Education, recognizes the *Idaho* Commission for the Blind and Visually Impaired (*ICBVI*) as the sole State Licensing Agency (SLA) under the provisions of the Randolph-Sheppard Vending Stand Act pursuant to Section 67-5411, Idaho Code, and has given to the Board of the *ICBVI* the legislative power to establish a Business Enterprise Program (BEP) pursuant to Section 67-5407(e), Idaho Code, and promulgate rules by the provisions of Section 67-5407(e), Idaho Code. (3-31-22)()

001. ~~TITLE AND SCOPE.~~

~~01. Title.~~ These rules are titled IDAPA 15.02.30, “Business Enterprise Program.” (3-31-22)

~~02. Scope.~~ These rules specify the conditions and standards under which the ~~Business Enterprise Program~~ BEP facilities are operated. (3-31-22)()

002. INCORPORATION BY REFERENCE

The following federal laws and regulations are incorporated by reference into the rules of this chapter and copies are available at the *ICBVI* office. ()

01. 20 U.S.C Ch. 6A Randolph-Sheppard Act. ()

02. 34 CFR 395. ()

03. Section 67-5402, 67-5411, 67-5909, 67-6901, 67-6902, 67-6903, 67-6904, and 67-6905, Idaho Code. ()

~~0023.~~ -- 009. (RESERVED)

010. DEFINITIONS.

~~Unless otherwise indicated in these rules,~~ The terms below are defined as follows: (3-31-22)()

01. Active Participation. An ongoing collaboration between the SLA and the Idaho Blind Merchants Committee (IBMC) on the development of Program rules, policies, standards, and procedures affecting the overall administration of the BEP, prior to being implemented by the SLA. ()

~~012.~~ Administrator. The Administrator of the ~~Commission~~ ICBVI. (3-31-22)()

~~02.~~ Agreement. An agreement between the Program and an operator for the operation of a vending

facility as a primary location. (3-31-22)

03. Benefits. Retirement or pension plans, health insurance contributions, and paid sick and vacation leave available only to operators. (See 34 CFR 395.8.) (3-31-22)()

04. Blind Person. A person who, after examination by a physician skilled in diseases of the eye or by an optometrist, whichever such person selects, has been determined to have the following (see 34 CFR 395.1(c)): (3-31-22)

a. Not more than twenty/two hundred (20/200) central visual acuity in the better eye with correcting lenses; or (3-31-22)

b. An equally disabling loss of the visual field as evidenced by a limitation to the field of vision in the better eye to such a degree that its widest diameter subtends an angle of no greater than twenty (20) degrees. (3-31-22)

04. Blind Licensee. A blind person licensed by the SLA to operate a vending facility on federal or other property. ()

05. Certified. Having successfully completed the Commission-approved training program established by the Program as a requirement for licensing. (See Section 150 of these rules.) (3-31-22)

06. Commission. The Idaho Commission for the Blind and Visually Impaired. (3-31-22)

07. Committee. The Idaho Blind Merchants Committee (IBMC). (3-31-22)

08.5. Contract. A contract with a licensee or other qualified individual for the operation of a vending facility. Contracts are of limited duration. An agreement with a government entity or other business for the operation of a cafeteria. (3-31-22)()

09.6. Contract Facility. A facility operated under a contract by a licensee or other party. In addition to Section 67-6902(2), Idaho Code, a vending enterprise is defined as: (3-31-22)()

10. Facility. A vending enterprise defined as: (3-31-22)

a. Automatic vending machines, cafeterias, snack bars, cart service, shelters, counters, and such other appropriate auxiliary equipment which may be operated by blind licensees and which is necessary for the sale of newspapers, periodicals, confections, tobacco products, foods, beverages, and other articles or services dispensed automatically or manually and prepared on or off the premises in accordance with all applicable health laws, and including the vending or exchange of chances for any lottery authorized by state law and conducted by an agency of a state within such a state. (See 34 CFR 395.1(x)); or (3-31-22)

b. Restaurants, cafeterias, snack bars, and goods and services customarily offered in connection with any of the foregoing, and includes vending machines dispensing foods when operated independently or in conjunction with such facilities. (See Section 67-6903, Idaho Code); or (3-31-22)

c. Any type of business which the Supervisor finds is consistent with and furthers the policies, goals, and objectives of the Program. (3-31-22)

a. A Vending Facility as defined in 34 CFR 395.1 (x) ()

b. Any business that sells articles or services consistent with the policies, goals, and objectives of the Program. ()

07. IBMC. A committee comprised of at least a Chair, Vice Chair, and Secretary, elected by the Idaho Vendors to represent their interests and actively participate with the SLA. ()

- 08. Operating Agreement (OA).** An agreement between the SLA and a Vendor or other qualified individual for the operation of a vending Facility or individual location. ()
- 11. License.** A written instrument issued by the state licensing agency to a blind person, authorizing such person to operate a vending facility on federal or other property. (See 34 CFR 395.1(i).) (3-31-22)
- 12. Licensee.** A blind person licensed by the state licensing agency to operate a vending facility on federal or other property. (See 34 CFR 395.1(b).) (3-31-22)
- 13. Operator.** A licensee assigned to and operating a primary location. (3-31-22)
- 1409. Permit.** The official approval given a state licensing agency to an SLA by a department, agency, or instrumentality in control of the maintenance, operation, and protection of federal property or person in control of other property, whereby the state licensing agency SLA is authorized to establish a vending facility. (See 34 CFR 395.1(e).) (3-31-22)()
- 15. Primary Location.** A single building or group of buildings operated as a vending facility pursuant to an agreement. (3-31-22)
- 1610. Probation.** A conditional status wherein a vendor has a specified period of time to correct identified problems before an agreement or contract may be terminated the operation of a facility by a Vendor or Provisional Licensee is being monitored for a specified period. (3-31-22)()
- 17. Program.** The Business Enterprise Program (BEP), provided for by the Randolph Sheppard Act to give priority to the blind in need of economic opportunities. (See 34 CFR 395.1(p) and Title 67, Chapter 69, Idaho Code.) (3-31-22)
- 1811. Property Manager.** The individual or entity in charge of administering vending issuing eContracts or permits in buildings on behalf of federal, state, or local government buildings or private buildings entities. (3-31-22)()
- 12. Provisional Licensee.** A trainee who is operating a facility during a six-month probationary period prior to becoming licensed as a BEP Vendor. ()
- 19. Satellite.** An ancillary site separate from a primary location granted to an operator as part of an agreement. (3-31-22)
- 20. Set Aside Funds.** Funds which accrue to a state licensing agency from an assessment against the net proceeds of each vending facility in the state's vending facility program and any income from vending machines on federal property which accrues to the state licensing agency. (See 34 CFR 395.1(s).) (3-31-22)
- 21. State Licensing Agency.** The Commission which has been designated by the Secretary of Education to issue licenses to blind persons for the operation of vending facilities on federal and other property. (See 34 CFR 395.1(v).) (3-31-22)
- 2213. Supervisor.** ~~The BEP individual who administers the Program~~ The individual designated to administer the BEP. (3-31-22)()
- 2314. Suspension.** Temporary withdrawal by the Supervisor of privileges granted by a license, ~~agreement or contract~~ or any OA during which time a vendor may not continue to operate a facility. (3-31-22)()
- 2415. Vendor.** ~~A licensee who operates a primary location with or without satellites, pursuant to an agreement, or who operates a contract facility pursuant to a contract~~ A Blind Licensee who is operating a vending facility on federal or other property. (3-31-22)()

011. PURPOSE. SEE U.S. DEPARTMENT OF EDUCATION – RANDOLPH SHEPPARD VENDING FACILITY PROGRAM.

The purpose of the Program is to provide remunerative employment opportunities for blind individuals who have an interest in and aptitude for operating a facility, to demonstrate alternative techniques for coping with blindness, and to educate the public regarding the ability of blind individuals to independently operate businesses. The Supervisor is responsible for the administration of the Program and reports to the Administrator. The Program shall be coordinated with other vocational rehabilitation programs of the Commission. (3-31-22)()

012. -- 029. (RESERVED)

030. LICENSES.

01. Issuance of Licenses. Licenses ~~shall be~~ do not expire and are issued ~~for an indefinite period of time and shall be issued~~ only to persons who are determined by the ~~Program SLA~~ to be: blind, a United States citizen, and certified by a vocational rehabilitation agency as qualified to operate a vending facility. (3-31-22)()

a. ~~Blind, as defined in Subsection 010.04 of these rules; and~~ (3-31-22)

b. ~~Citizens of the United States; and~~ (3-31-22)

c. ~~Certified by the Program as qualified and trained to operate a facility.~~ (3-31-22)

02. Inactive License. ~~If a licensee, who is not an operator, fails for more than one (1) year to bid for a facility, the license of such licensee shall become inactive~~ A license will become inactive if a Blind Licensee fails to bid for a facility for more than one (1) year. (3-31-22)()

03. Reactivation. A license can be reactivated upon written request to the Supervisor. The ~~Supervisor may require a Blind licensee~~ may be required to repeat some of the certification requirements ~~to reactivate a license outlined in internal controls.~~ (3-31-22)()

031. OPERATING AGREEMENTS.

To operate a facility, an individual must enter into an OA with the SLA that specifies the rights and responsibilities of each party as they relate to the operation of a facility. ()

01. SLA Responsibilities. In addition to the responsibilities stipulated by the OA and Idaho Code, the SLA will: ()

a. Periodically audit, or cause to be audited, the Vendor's records and financial data to verify the accuracy of the set aside report; and ()

b. Provide information or make available data in suitable format at the Vendor's request provided that such disclosure does not violate applicable federal or State laws pertaining to the disclosure of confidential information. ()

c. Make each facility's signed OA available to all Vendors. ()

02. General Rights and Responsibilities. ()

a. The Vendor is encouraged to hire blind persons or persons with other disabilities when feasible. ()

b. The Vendor shall report any unresolved complaints of the Property Manager to the Supervisor within one (1) business day. ()

c. The Vendor may, with written approval of the Supervisor, negotiate with Property Managers for

additional facilities. ()

d. In the event of any dispute, the OA is governed by the jurisdiction of the state courts of Ada County in the state of Idaho unless said dispute is due to a violation of the Randolph-Sheppard Act in which case jurisdiction falls under the Randolph-Sheppard Act arbitration provisions with appeal to federal district court. ()

0342. -- 039. (RESERVED)

040. **TERMINATION AND SUSPENSION OF LICENSES AND /OR OPERATING AGREEMENTS.**

01. Grounds for License Termination. Except in emergency situations, probation occurs prior to termination. Licenses are subject to termination after fifteen (15) business days' notice if the Program SLA finds: (3-31-22)()

~~a. That the facility is not being operated in accordance with Commission rules, the terms and conditions governing the permit, or the terms and conditions of the agreement or contract (See Section 140 of these rules.);~~ (3-31-22)

~~b. That the licensee no longer meets the definition of blind person as set out in Subsection 010.04 of these rules;~~ (3-31-22)

~~c. That the licensee has received a medically documented diagnosis that will result in prolonged incapacity of the licensee and a continuing inability to operate a facility;~~ (3-31-22)

~~d. That the licensee has withdrawn from the Program by submitting written notification to the Supervisor;~~ (3-31-22)

~~e. That the licensee has made unauthorized use of retirement account funds; or~~ (3-31-22)

~~f. That the licensee engages in conduct or allows a condition to exist for which the licensee has previously been placed on probation, or which has previously led to the suspension of the license.~~ (3-31-22)

a. That the Vendor engages in conduct or allows a condition to exist for which the Vendor has previously been placed on Probation, or which has previously led to the suspension of the License or OA; ()

b. That the facility is not being operated in accordance with SLA rules, the terms and conditions governing the Permit, Contract, or OA; ()

c. That the Vendor no longer meets the definition of blind person. ()

[Proposed new Subsections 040.01.d. and 040.01.e. have been withdrawn]

02. Grounds for OA Termination. An OA may be terminated if: ()

a. The health and safety of the Vendor, the employees, or the customers are jeopardized; ()

b. The Vendor jeopardizes the state's investment in the facility by violating the terms of the Permit, Contract, or OA; applicable federal, state, or local laws, rules, and regulations; or by placing the facility in danger of being closed; ()

c. The business and premises of the facility are not covered by adequate insurance; ()

d. That the Vendor has received a medically documented diagnosis that will result in their being incapacitated or unable to oversee the operation of a facility for more than one (1) year. ()

03. Grounds for License Suspension. The Supervisor has the authority to suspend the license of a

Vendor whose conduct may jeopardize a Contract, Permit or the Program. ()

04. Grounds for *OA* Suspension. Any *OA* may be suspended if: ()

a. The Vendor has committed any of the acts enumerated in Subsection 040.02 of these rules; or ()

b. The Property Manager requests the removal of the Vendor and documents the request in writing. The Vendor will have three (3) business days to respond; and the SLA will determine if immediate removal of the Vendor is in the best interest of the Program; or ()

c. The Supervisor and the Vendor cannot agree on a plan to resolve violations and improve performance. ()

025. Notice of Termination or Suspension. ~~Notice shall be in writing, specify the grounds upon which the notice of termination is based; and advise the operator of his right to administrative review and a full evidentiary hearing~~ A written notice, in accessible format, will be provided to the Vendor that includes the specific grounds for termination or suspension and outlines a Vendor's right to pursue an evidentiary hearing within fifteen (15) business days following the issuance of this notice. (3-31-22)()

036. Request for Review ~~Not a Stay.~~ A timely filed request for administrative review shall not stay the termination of the license. If the Vendor seeks an evidentiary hearing, and any subsequent appeals including arbitration, and prevails during the proceedings, all rights and benefits are restored to the Vendor including compensation for the period the license or *OA* was terminated or suspended. Compensation is calculated at a weekly rate determined by averaging the net income of the facility for a designated period prior to the notice of termination or suspension. The designated timeframes are: (3-31-22)()

a. The prior federal fiscal year in the case of license terminations; or ()

b. The eight (8) weeks prior to the notice of termination in the case of any terminated *OA*; or ()

c. The eight (8) weeks prior to the notice of suspension in the case of any suspended *OA* or license. ()

047. Termination. ~~The termination becomes effective following the fifteen (15) day notice period unless the vendor seeks administrative review, in which case the license may be suspended and any contract or agreement may be terminated pending completion of the administrative review, full evidentiary hearing, and subsequent appeals. Until the review process has been concluded, the Program shall operate the facility. At the conclusion of the review process, should the vendor prevail, the Program shall restore all rights and benefits to the vendor including compensation for the period of termination calculated at a weekly rate determined by averaging the net income for the facility for the prior federal fiscal year~~ The termination becomes effective following the fifteen (15) business day notice period unless the Vendor seeks an evidentiary hearing, in which case the license may be suspended, and any *OA* may be terminated pending completion of the evidentiary hearing and subsequent appeals, including arbitration. (3-31-22)()

058. Suspension. ~~The Supervisor has the authority to suspend the license of a vendor whose conduct may jeopardize a permit or the Program.~~ (3-31-22)

a. ~~The Supervisor shall notify the vendor in writing of the suspension and identify the specific deficiencies and the time allowed for the vendor to take corrective action. If no resolution has been made at the end of the specified time, the Supervisor shall issue a notice of termination.~~ (3-31-22)

b. ~~If the Supervisor and a vendor, whose license has been suspended, cannot agree on arrangements for a temporary replacement vendor, the procedures set out in Section 180 of these rules shall be followed to resolve the matter~~ Suspension may continue up to one hundred eighty (180) calendar days. If the Vendor seeks an evidentiary hearing and arbitration, the suspension will continue until the evidentiary hearing, arbitration, and subsequent

proceedings have concluded.

(3-31-22)()

069. Operating Agreement OA Cancellation. The Supervisor has the authority to place a vendor who is not in compliance with the terms of an agreement or contract on probation. The Supervisor shall notify the vendor in writing of the probation and identify the specific deficiencies and the time allowed for the vendor to take corrective action. If no resolution has been made at the end of the specified time, the Supervisor shall issue a notice of termination. An OA may be cancelled by the SLA at any time should the facility cease to be a vending facility by revocation of the Permit by the Property Manager. Cancellation under this subsection will not affect licensure.

(3-31-22)()

10. License Probation. The Supervisor has the authority to place a Vendor who is not in compliance with the terms of an OA on Probation. The Vendor is provided written notification in their preferred format of the Probation including the specific deficiencies and the timeframe to complete corrective action. A notice of termination will be issued if corrective action is not completed within the time frame.

()

0711. Improvement Plans. If the Supervisor receives a set aside report from a vendor that indicates no profit has been realized during two (2) consecutive months or three (3) months in a fiscal year the Supervisor shall review the situation and, with the vendor, devise a plan with measurable objectives and timetables for improvement. Should the facility not show a reasonable profit during the three (3) subsequent months the Supervisor may issue a notice of termination or the facility may be contracted or closed. If a Vendor's set aside report indicates that no profit has been realized during three (3) consecutive months or five (5) months in a fiscal year, or if a Vendor requests intervention due to other deficiencies, a review will be initiated. The Supervisor and Vendor will determine a six (6) month plan for improvement with measurable objectives. Should the facility not show reasonable improvements during that time, the Supervisor may issue a notice of termination of the OA or close the facility.

(3-31-22)()

041. -- 049. (RESERVED)

050. SELECTION OF ~~OPERATORS~~ VENDORS.

01. Notification of Opening. The Supervisor shall notify all licensees and prospective operators, all commissioners and counselors of the Commission of all facility openings in writing. The notice of openings shall also be posted on the Commission web site. The notice shall state the facility location, the application procedure, and the deadline for application. The notice shall also solicit interest in operating the facility on a contract, in the event it is not awarded as a primary location. Interested parties will be provided specific information about the openings upon request. Written notification of any facility opening will be provided to all Vendors, Blind Licensees, Provisional Licensees and Trainees, Board of Commissioners, and VR Counselors of the ICBVI. The notice includes the facility location, application procedure, submission, and deadline.

(3-31-22)()

02. Qualification of Bidders. A bidder for a primary location facility shall be: (3-31-22)

a. Licensed by the Commission; SLA or in training as a Provisional Licensee. (3-31-22)

b. Current in financial good standing with Program payments, including monthly set asides and any other monies due the Program; and (3-31-22)

c. In good standing and whose license has not have been suspended or placed on probation or had his license suspended within the last calendar year. (3-31-22)()

03. No Qualified Bidders. If no applications are received from qualified bidders, licensees who expressed an interest in operating the facility as a contract facility will be given priority in the selection of a contractor. If no licensee is awarded the facility, the Supervisor may award a contract one- (1) year OA to any qualified individual food service business with a registered EIN.

(3-31-22)()

04. Application. An application shall will be in the form of a written letter to the Supervisor and

include a statement of qualifications and pertinent experience. (3-31-22)()

05. **Selection ~~Process~~ Panel.** A panel is appointed to review all applications and conduct interviews. (3-31-22)()

a. ~~The Supervisor shall appoint a panel to review all applications and conduct interviews~~ The panel includes the Supervisor serving as chair, a representative *Vendor* selected by the IBMC Chair, and one (1) person from field services who will be selected through active participation. No member of the selection panel will have a conflict of interest with the applicants. (3-31-22)()

~~b. The panel shall consist of the Supervisor who serves as chair, a representative of the Committee selected by the Committee chair, and one (1) person from field services. The person from field services shall not have had a client relationship with the applicants.~~ (3-31-22)

~~eb.~~ The panel ~~shall~~ reviews all written applications and conducts interviews ~~at least with~~ the top five (5) candidates; using the same format and interview questions. All members of the panel must be ~~physically~~ present during the interviews. (3-31-22)()

~~ec.~~ A weighted evaluation form ~~shall be~~ is used by each panel member. Selection criteria ~~shall~~ will be consistent with the job requirements of that facility. ~~Points shall be given by each interviewer to each candidate in the various categories assessed. A composite score shall be tabulated for each candidate.~~ (3-31-22)()

~~ed.~~ The Supervisor ~~shall~~ make a final selection from the two (2) candidates with the highest total points. If the candidate with the highest score is not selected, the Supervisor ~~must~~ will provide an written explanation ~~in writing to the highest scoring candidate upon request with the documentation that supports the decision. In the event of a tie, the facility will be awarded to the bidder with the highest seniority.~~ (3-31-22)()

~~fe.~~ If no bidder is awarded operation of the facility, the Supervisor may grant ~~it on a contract~~ a one- (1) year OA to a *Vendor, Blind Licensee, Provisional Licensee,* or other ~~qualified individual~~ food-service provider with a registered EIN. (3-31-22)()

06. **Notification of Decision.** ~~The Supervisor shall notify all applicants in writing of the final decision~~ Written notification of final decision is provided to all applicants. (3-31-22)()

~~07. Records.~~ The Supervisor shall maintain a record of all proceedings. (3-31-22)

~~087. Transfer and Promotion.~~ ~~The procedure for transfer and promotion shall be the same as for original selection of vendors~~ Licenses, OAs, and Contracts are not transferable and must go through the original selection process. (3-31-22)()

051. -- 059. (RESERVED)

060. **ACCESS TO PROGRAM AND FINANCIAL INFORMATION.**

~~Each licensee in the Program shall be provided access to all Program financial data relevant to the operation of the Program, including annual financial reports, provided that such disclosure does not violate applicable federal or state laws pertaining to the disclosure of confidential information. Insofar as practical, such data shall be made available in suitable alternative format. At the request of a licensee, qualified staff of the Program shall arrange a convenient time to assist in the interpretation of the financial data~~ See 34 CFR 395.12. (3-31-22)()

061. -- 069. (RESERVED)

070. **EQUIPMENT, INITIAL STOCK AND BUSINESS EXPENSES.**

01. ~~Program Responsibility~~ **SLA Responsibilities.** ~~The Program SLA~~ assumes full responsibility for providing each facility established under the Program with adequate equipment and initial stock of merchandise.

(3-31-22)()

02. Initial Stock of Merchandise. ~~An initial stock of merchandise shall be provided by the Supervisor. The Supervisor shall determine the quantity of the initial stock, which shall be enough for at least one (1) full week of operation. The vendor shall account for the value of the initial stock when the operation is concluded.~~ An initial stock of merchandise for a minimum of two (2) full weeks of operation is provided to the Vendor. (3-31-22)()

03. Vending Machine Contracts. ~~The Program shall negotiate contracts with vending companies for installation or location of vending machines in or to be assigned to facilities.~~ (3-31-22)

04. Insurance. ~~All vendors shall be responsible for~~ must obtaining general liability, product liability, and worker's compensation insurance. ~~and provide~~ Pproof of insurance ~~must be sent to the Supervisor prior to the start of operation and within ten (10) days of~~ the policy renewal date. (3-31-22)()

071. MAINTENANCE AND REPLACEMENT OF EQUIPMENT.

~~The Program shall maintain or cause to be maintained all equipment in a safe and satisfactory working condition. Replacement in lieu of repair shall be a decision of the Supervisor. It is the vendor's responsibility to report any incident resulting in damage, breakage, theft, defacement, or malfunction of equipment or fixtures as soon as possible. Vendors are authorized to arrange for minor repairs or replacement of small equipment where the total cost does not exceed three hundred dollars (\$300). Repair shall be deemed unauthorized when the repair or replacement is attributable to negligent actions by the vendor or when the equipment or fixtures are not the maintenance responsibility of the Program.~~ See 34 CFR 395.10. The Vendor must report any incident resulting in damage, breakage, theft, defacement, or malfunction of equipment or fixtures within three (3) days, and arrange repair or replacement with the SLA. The SLA will not be responsible for or cover the cost of repairs that are due to negligent actions of the Vendor or for equipment or fixtures not covered under an OA. (3-31-22)()

072. OPERATOR VENDOR OWNERSHIP OF VENDING FACILITIES.

~~The Commission~~ SLA does not vest title to state-purchased equipment and stock in ~~an operator~~ a Vendor. (3-31-22)()

073. -- 099. (RESERVED)

100. SETTING ASIDE OF FUNDS.

See 34 CFR 395.9. ()

01. Set Aside. ~~The Commission may set aside, or cause to be set aside, from the net profit of the operation of facilities, funds for the purposes of maintenance and replacement and purchase of equipment.~~ (3-31-22)

02. Other Purposes Allowed by the Randolph-Sheppard Act. ~~The Commission reserves the right to use set aside funds for other purposes as permitted in accordance with the provisions of the Randolph-Sheppard Act and federal rules and regulations.~~ (3-31-22)

03. Approval by the United States Department of Education. ~~The funds set aside for those specified purposes shall not exceed the amount determined reasonable by the Rehabilitation Services Administration Commissioner, U.S. Department of Education.~~ (3-31-22)

04. Record of Expenditures. ~~The charge for each of the program purposes cited shall be determined on the basis of records of expenditures made for each of these purposes over a reasonable period of time with allowances for improving services, fluctuations in costs and program expansion. Adequate records shall be maintained to support the charges for each of the purposes cited.~~ (3-31-22)

05. Increases. ~~At no time shall the set aside charges be increased without prior consultation with the Committee.~~ (3-31-22)

06. Review of Schedule of Funds. ~~The schedule of funds to be set aside shall be reviewed periodically by the Supervisor and the Committee. After reviewing the accounting records and other criteria pertinent to the~~

administration of the Program, it may be necessary to revise the set aside payment schedule. (3-31-22)

~~07. Income with No Program Operator.~~ Vending machine income received from federal sites where there is no licensed Program operator shall be used for those purposes designated by the Committee in accordance with 34 CFR 395.8. (3-31-22)

101. DISTRIBUTION AND USE OF INCOME FROM VENDING MACHINES ON FEDERAL PROPERTY.

See 34 CFR 395.8. ()

~~01. Limitations.~~ No limitation shall be imposed on income from vending machines combined to create a facility when such facility is maintained, serviced or operated by a program vendor. (3-31-22)

~~02. Vending Machine Income.~~ The Program shall manage vending machine income disbursed by a property managing department, agency or instrumentality of the United States in accordance with the requirements of 34 CFR 395.8. (3-31-22)

102. -- 119. (RESERVED)

120. OPERATOR-VENDOR BENEFITS.

See 34 CFR 395.8(c). ()

~~01. Vending Machine Income.~~ The Program shall provide licensees with information regarding benefits. Upon a majority vote of licensees, the Program may retain vending machine income from federal property in accordance with 34 CFR 395.8(a). Such income may be used for the establishment and maintenance of retirement or pension plans, for health insurance contributions, and for the provision of paid sick leave and vacation time for operators. Distribution of benefit payments shall be determined by a majority vote of licensees and established as policy. (3-31-22)

~~02. Eligibility.~~ Only operators of a primary location pursuant to an agreement shall be eligible to receive benefits. There shall be a ninety (90) day waiting period before a new operator is eligible to receive benefits. Benefit payments will not be interrupted when an operator transfers from one primary location to another. Benefits shall be paid only after the appropriate documentation is submitted to the Program. (3-31-22)

~~03. Medical Insurance.~~ If a majority of licensees determines that operators shall be reimbursed for medical insurance premiums, operators shall be responsible for acquiring their own policies. The Program shall reimburse the operator in an amount determined by the vote of licensees. Operators shall provide documentation to the Program proving payment of their premiums, prior to any reimbursement. (3-31-22)

~~04. Retirement and Pension Accounts.~~ If a majority vote of licensees determines that operators shall have retirement accounts, the Program shall deposit into approved retirement accounts an amount determined by a majority vote of licensees, up to the maximum federal allowance for IRAs per year. The funds shall be deposited on a monthly basis directly into each operator's retirement account. (3-31-22)

~~05. Sick Leave and Vacation Funds.~~ If a majority vote of licensees determines that operators shall have sick or vacation leave funds, or both, the Program shall remit to each operator an amount determined by a majority vote of licensees. (3-31-22)

01. Eligibility. Only vendors operating a facility pursuant to an OA are eligible to receive benefits. ()

062. Non-Fully Funded Benefits. If funds are not available for full payment of benefits, as voted by the licensees, the Program may pro-rate the payments from available funds, unless another method of disbursement of non-fully funded benefits was voted by a majority of the licensees. Vendors, the SLA may pro-rate the payments from available funds, unless another method of disbursement of non-fully funded Benefits was voted by a majority of the Vendors operating a facility. (3-31-22)()

121. -- ~~129.~~ ~~(RESERVED)~~

~~130. AGREEMENTS/CONTRACTS.~~

~~Vendors shall enter into an agreement or a contract with the Program that specifies the rights and responsibilities of the operator and Program as they relate to the operation of a primary location and any satellites. The contract shall specify the rights and responsibilities of the licensee or qualified operator and Program as they relate to the operation of a contract facility.~~ (3-31-22)

- ~~**01. Program Responsibilities.** The Program shall:~~ (3-31-22)
- ~~**a:** Equip the facility for carrying out the business authorized by the permit;~~ (3-31-22)
- ~~**b:** Furnish initial stocks of merchandise sufficient to enable the vendor to commence operating the business. The Program shall also furnish the vendor with an inventory list of all equipment and initial stock;~~ (3-31-22)
- ~~**c:** Provide for the maintenance of the equipment and replace obsolete and worn out equipment as necessary;~~ (3-31-22)
- ~~**d:** Provide, or provide for supervisory and management services as deemed appropriate by the Supervisor for efficient operation;~~ (3-31-22)
- ~~**e:** Periodically audit, or cause to be audited, the vendor's records and financial data to verify the accuracy of the set aside report; and~~ (3-31-22)
- ~~**f:** Provide information or make available data in suitable format at the vendor's request when possible.~~ (3-31-22)

- ~~**02. Vendor Responsibilities.** The vendor shall:~~ (3-31-22)
- ~~**a:** Have the facility open for business as specified in the permit. Exceptions may be approved in advance by the Supervisor;~~ (3-31-22)
- ~~**b:** Operate on a cash basis. The Program shall not be responsible for bills incurred by the vendor. The vendor is responsible for notifying suppliers that the vendor alone is responsible and shall verify that notification by use of the purveyor letter supplied by the Program;~~ (3-31-22)
- ~~**c:** Be accountable to the Program for the income of the facility;~~ (3-31-22)
- ~~**d:** Provide for a temporary worker in the vendor's absence because of illness, vacation, or other causes. The salary of the person who substitutes for the vendor, or that of other emergency help, shall be paid for by the vendor. The vendor shall notify the Program a reasonable time in advance of taking any voluntary leave, and as soon as possible with respect to any involuntary leave;~~ (3-31-22)
- ~~**e:** Carry on the business of the facility in compliance with the permit and applicable health laws and regulations and make available to the Program copies of inspection reports;~~ (3-31-22)
- ~~**f:** Maintain a neat, business-like appearance while working at the facility, and conduct business in an orderly, professional manner;~~ (3-31-22)
- ~~**g:** Take proper care of the equipment and not make structural alterations or changes to the facility without written approval of the Program;~~ (3-31-22)
- ~~**h:** Keep appropriate records and send a monthly report and set aside payment to the Program by the fifteenth day of the following month as required. Late reports or payments will be resolved in the manner set forth in Section 040 of these rules;~~ (3-31-22)

~~i. Be responsible for the day to day management of the facility. For staffed facilities, the vendor should be present the majority of the time the facility is staffed for service to the public. For vending only facilities, the Supervisor and vendor will mutually agree on the hours that the vendor shall be at the facility, and the agreement shall become an addendum to the contract or operating agreement; and~~ (3-31-22)

~~j. The vendor shall provide copies of proof of insurance as required by Subsection 070.04 of these rules.~~ (3-31-22)

03. General Rights and Responsibilities. (3-31-22)

~~a. The business to be conducted shall be limited to that specified and authorized in the permit or contract between property managing agency and the Program.~~ (3-31-22)

~~b. The right, title to, and interest in the equipment and initial inventories of the facility are vested in the Program. At termination of the operating agreement, a value equal to that assigned to the outgoing vendor as beginning inventory will be returned to the Program. The Program will determine what inventory will be accepted from the outgoing vendor. The outgoing vendor shall have receipts no more than ninety (90) days old to show the value of inventory. Any inventory refused by the Program will become the property of the outgoing vendor. If the takeover inventory is less than initially assigned, the outgoing vendor will pay the difference in cash. If the Program agrees to accept more inventory than was initially assigned, the Program will reimburse the outgoing vendor in cash.~~ (3-31-22)

~~c. The monthly income of the vendor shall be the net profit for the period in question; the expenses shall be in accordance with the monthly set aside report as developed by the Program and the Committee.~~ (3-31-22)

~~d. Rebates, commissions, or bonuses received by the vendor from suppliers shall be reported as income. Such income is not to be treated as the separate, personal income of the vendor.~~ (3-31-22)

~~e. Merchandise taken from the stock in trade of the facility by the vendor for personal use shall be paid for at cost.~~ (3-31-22)

~~f. The business and premises shall be covered by adequate comprehensive and product liability insurance, and any such other insurance as will protect the vendor and anyone employed by the vendor against losses and claims arising out of the conduct of the business or which are required by law. The dollar amount of insurance shall be fixed by the Program and the Committee using industry standards and state requirements as guidelines to assure up-to-date coverage. The cost of such insurance shall be a cost of operating the business of the facility and taken into account as such in determining the net proceeds of the business operation.~~ (3-31-22)

~~g. After an initial commitment to operate a primary location for twelve (12) months, an agreement may be terminated at anytime by the operator with at least thirty (30) days written notice to the Program. During the initial twelve (12) month period, the operator cannot bid on other primary locations without the consent of the Supervisor.~~ (3-31-22)

~~h. The operator is encouraged to hire blind persons or persons with other disabilities when feasible.~~ (3-31-22)

~~i. The vendor shall report promptly to the Supervisor any unresolved complaints of the property manager.~~ (3-31-22)

~~j. The vendor may, with written approval of the Supervisor, negotiate with property managers for additional facilities.~~ (3-31-22)

~~k. A vendor may purchase equipment for a facility only if the purchase is approved in advance, in writing, by the Supervisor. The Program, in its sole discretion, has the first option to purchase from the vendor any equipment purchased without advance, written approval.~~ (3-31-22)

131.—139. (RESERVED)

140. ~~TERMINATION AND SUSPENSION OF AGREEMENTS/CONTRACTS.~~

- ~~01. Grounds for Termination.~~** Agreements and contracts may be terminated if: (3-31-22)
- ~~a.~~** The vendor is not operating the facility on a cash basis; (3-31-22)
- ~~b.~~** The health and safety of the vendor, the employees, or the customers are jeopardized; (3-31-22)
- ~~c.~~** The set aside report indicates the vendor did not show an average one thousand dollar (\$1,000) net profit per month, after set aside payment, for the prior federal fiscal year; (3-31-22)
- ~~d.~~** The vendor jeopardizes the state's investment in the facility by violating the terms of the permit, agreement or contract, or by placing the facility in danger of being closed; (3-31-22)
- ~~e.~~** The business and premises of the facility are not covered by adequate insurance; (3-31-22)
- ~~f.~~** The facility is not being operated in accordance with the agreement, contract, Commission rules, or with applicable federal, state, or local laws, rules, and regulations; (3-31-22)
- ~~02. Notice of Termination.~~** The notice shall be in writing and specify the grounds upon which the notice of termination is based and advise the vendor of his right to administrative review and a full evidentiary hearing. (3-31-22)
- ~~03. Request for Review Not a Stay.~~** A timely filed request for administrative review shall not stay the termination of an agreement or contract. (3-31-22)
- ~~04. Review.~~** The termination becomes effective following the fifteen (15) day notice period unless the vendor seeks administrative review, in which case the License may be suspended and any contract or agreement may be terminated pending completion of the administrative review, full evidentiary hearing, and subsequent appeals. Until the review process has been concluded, the Program shall operate the facility. At the conclusion of the review process, should the vendor prevail, the Program shall restore all rights and benefits to the vendor including compensation for the period of termination calculated at a weekly rate determined by averaging the net income for the facility for the eight (8) weeks prior to the notice of termination. (3-31-22)
- ~~05. Grounds for Suspension.~~** Agreements and contracts may be suspended if: (3-31-22)
- ~~a.~~** The vendor has committed any of the acts enumerated in Subsection 140.01 of these rules; or (3-31-22)
- ~~b.~~** The property manager requests the removal of the vendor and documents the request in writing, and the Program determines that immediate removal of the vendor is in the best interest of the Program; or (3-31-22)
- ~~c.~~** The Supervisor and the vendor cannot agree on a plan to resolve violations and improve performance. (3-31-22)
- ~~06. Notice of Suspension.~~** A written notice of suspension shall be delivered to the vendor and shall state the reason for the suspension. Suspension may continue up to sixty (60) days. If the vendor seeks administrative review of the suspension, the suspension shall continue until the administrative review, evidentiary hearing, and subsequent proceedings have concluded. During the suspension, the facility shall be operated by the Program. At the conclusion of the review process, should the vendor prevail, the Program shall restore all rights and benefits to the vendor including compensation for the period of termination calculated at a weekly rate determined by averaging the net income for the facility for the eight (8) weeks prior to the notice of termination. (3-31-22)
- ~~07. Cancellation.~~** An agreement or contract may be cancelled by the Program at any time should the facility cease to be a vending facility by revocation of the permit by the property manager. Cancellation under this Subsection shall not affect licensure and does not give rise to a right to administrative review, evidentiary hearing or

other relief. (3-31-22)

~~141.~~ 149. (RESERVED)

150. TRAINING-PROGRAM CURRICULUM.

01. Certification Licensing. Prior to certification, an applicant shall satisfactorily complete the training program established by the Program and any on-the-job training prescribed by the Supervisor. The training program shall have certain basic requirements but also be customized to meet the needs of each individual applicant. The training program shall include, but is not limited to: fundamentals of purchasing, inventory control, pricing, record keeping and other accounting systems; display and arrangement of merchandise and equipment; and public relations and promotion. A candidate becomes licensed after completing the training curriculum established by the SLA which is comprised of general non-visual skills training, core BEP subjects, on-the-job training, and a six-month probationary period during which a trainee is to operate a facility. (3-31-22)()

02. In-Service Training. The ~~Program shall~~ SLA provides each ~~v~~Vendor with regular and systematic assistance and in-service training to: promote maximum returns to the ~~v~~Vendor; maximum service to the clientele; maintenance of a clean and attractive place of business; utilization of sound business practices; and adherence to the Commission's SLA's rules, policies, and building management requirements. (3-31-22)()

03. Post-Employment Services. Post-employment services may be provided to eligible vendors when necessary to assure that they maintain suitable employment within the agency's Business Enterprise Program. Eligibility for and provision of post-employment services shall be in accordance with IDAPA 15.02.02, "Vocational Rehabilitation Services." (3-31-22)

151. -- 159. (RESERVED)

160. IDAHO BLIND MERCHANT'S COMMITTEE (IBMC).

See 34 CFR 395.14. IBMC representatives shall be elected by the Vendors at a regular meeting and serve in their respective roles for two (2) years. ()

01. Committee Name. The Program shall provide for a state committee of blind vendors per the Randolph-Sheppard Act (See 34 CFR 395.14.) The name of this committee is the Idaho Blind Merchants Committee (IBMC). (3-31-22)

02. Purpose of Committee. The purpose of the Committee is to: (3-31-22)

a. ~~Actively participate with the Commission in major administrative decisions and policy and program development decisions affecting the overall administration of the Program;~~ (3-31-22)

b. ~~Receive and transmit to the Commission grievances at the request of vendors and serve as advocates for such vendors in connection with such grievances;~~ (3-31-22)

c. ~~Actively participate with the Commission in the development and administration of a system for the transfer and promotion of vendors;~~ (3-31-22)

d. ~~Actively participate with the Commission in the development of training and retraining programs for vendors; and~~ (3-31-22)

e. ~~Sponsor, with the assistance of the Commission, meetings and instructional conferences for vendors within the state.~~ (3-31-22)

[Proposed new Subsection 160.01 has been withdrawn]

03. Bylaws. The Committee shall, by a two-thirds (2/3) majority vote, adopt bylaws, consistent with the Randolph-Sheppard Act, which govern the internal operation of the Committee. The Vendors shall, by a majority

vote, adopt bylaws, consistent with the Randolph-Sheppard Act, which govern the internal operation of the IBMC.

(3-31-22)()

04. Committee Membership. The Committee comprises the operators of all facilities in the state.

(3-31-22)

05. Executive Board. An executive board consisting of a chair, vice chair, secretary, and two (2) at large representatives shall be elected by the Committee at a regular meeting. Members of the executive board shall serve for two (2) years in their respective positions. The executive board may conduct all business of the Committee between regular meetings of the Committee.

(3-31-22)

161. -- 169. (RESERVED)

170. MEETINGS OF THE COMMITTEE.

01. Annual Meetings. The ~~Committee~~ IBMC shall hold at least one (1) regular meeting each calendar year.

(3-31-22)()

02. Additional Meetings. The Committee may provide for additional meetings in its bylaws.

(3-31-22)

03. Program Responsibilities. The ~~Program shall~~ SLA will work with the ~~Committee~~ IBMC eChair or designated representative to coordinate and participate in the regular meetings of the ~~Committee~~. ~~At regular meetings, the Program shall give financial and overview reports, review Program rules and policies; and receive Committee recommendations for changes to the Program rules or policies~~ IBMC.

(3-31-22)()

04. Expenses. The SLA pays Allowable expenses of not more than two (2) regular meetings per calendar year may be paid out of Program monies. Allowable expenses include ing meeting rooms, lodging, per diem, and transportation. of not more than two (2) regular meetings per calendar year. The transportation arrangements shall be are determined by the Supervisor. Expenses for additional meetings of the ~~Committee~~ IBMC may be paid by the Program at the discretion of the ~~Supervisor after consultation with the Administrator~~ SLA.

(3-31-22)()

05. Future Meeting. The date and time for the next regular meeting shall be set prior to adjournment.

(3-31-22)

06. Minutes. ~~Minutes shall be kept by the Committee and made available to the Supervisor. Minutes shall be sent to each operator and to the Supervisor within ninety (90) days after conclusion of the meeting.~~ See Section 74-205, Idaho Code. The Program ~~shall~~ will pay all reasonable costs for this service.

(3-31-22)()

171. -- ~~179.~~ (RESERVED)

180. ADMINISTRATIVE REVIEW.

01. Request for Review. A vendor who is aggrieved by any action or failure to act arising from the operation or administration of the Program may ask for a review of the action by filing a written request with the Administrator. The written request for review, which may be filed by the vendor or a designated representative of the vendor, shall specify the matter to be reviewed and how the vendor has been aggrieved.

(3-31-22)

02. Response. Upon receipt of a request for administrative review, the Administrator shall notify the Supervisor, who has fifteen (15) calendar days to file a written response to the request. A copy of the Supervisor's response shall be sent to the vendor or the vendor's designated representative.

(3-31-22)

03. Filing Objections, Replies, and Decisions. Upon receipt of the response from the Supervisor, the vendor or the vendor's designated representative has fifteen (15) calendar days in which to file any objections or make reply, after which time the Administrator shall, in good faith, evaluate the materials submitted and issue a written decision within fifteen (15) calendar days. The vendor or the vendor's designated representative may request

~~an evidentiary hearing in accordance with Subsection 190.01 of these rules if the decision issued by the Administrator fails to resolve the vendor's grievance(s).~~ (3-31-22)

~~181.~~ 189. (RESERVED)

189. INFORMAL DISPUTE RESOLUTION. SEE IDAPA 15.02.01.150.01.

A candidate going through the BEP training curriculum or a Provisional Licensee who disagrees with the actions of the SLA may request an Informal Dispute Resolution with the Rehabilitation Services Chief. ()

190. ~~FULL~~ EVIDENTIARY HEARING.

01. Request. The ~~Commission shall~~ ICBVI will provide a vVendor or Blind Licensee an opportunity for ~~an full~~ evidentiary hearing. The vVendor, Blind Licensee, or ~~the vendor's~~ designated representative may request ~~an full~~ evidentiary hearing ~~following the receipt of an unfavorable decision issued by the Administrator pursuant to Subsection 180.03 of these rules by filing a complaint.~~ The written request ~~shall will~~ be delivered to the Administrator, ~~with a copy to the Committee chair,~~ within fifteen (15) ~~calendar~~ business days of the aggrieved party's ~~receipt of the Administrator's decision~~ filed complaint. (3-31-22)()

02. Suspension. ~~If the conduct of the vendor places the facility or permit in jeopardy, the Supervisor may suspend or terminate the agreement or contract pending the decision of the full evidentiary hearing.~~ (3-31-22)

032. Time and Place of Hearing. The evidentiary hearing ~~shall will~~ be held in the ~~Commission~~ ICBVI headquarters at a mutually convenient time. (3-31-22)()

043. Time Limit. The hearing procedure ~~shall will~~ be limited to ninety (90) calendar days, beginning on the date the request for hearing is filed by the vVendor. The time limit may be extended due to illness of the vVendor or delay in obtaining evidence because of circumstances beyond the control of the vVendor or the ~~Program~~ SLA. (3-31-22)()

054. Hearing Officer. ~~The Administrator shall will request the Idaho Office of Administrative Hearings to appoint an attorney as the~~ hHearing oOfficer to conduct the evidentiary hearing and issue a report. (3-31-22)()

065. Hearing Notice. A notice of the hearing date ~~shall will~~ be provided to the vVendor or Blind Licensee at least twenty-one (21) calendar days prior to the date set for the hearing. (3-31-22)()

076. Legal Counsel. The vVendor or Blind Licensee may arrange to have legal counsel or other representation. Such counsel shall be at the expense of the vVendor. (3-31-22)()

087. Evidence. The hHearing oOfficer shall make a reasonable effort to obtain the most credible evidence of fact in the case, and the rules of evidence do not apply. (3-31-22)()

098. Conduct of Hearing. Each party ~~shall will~~ be given an opportunity to present its case, examine and cross-examine witnesses, present arguments, and rebut evidence. (3-31-22)()

~~1009.~~ **Transcripts.** A transcript of the proceedings ~~shall will~~ be made available to the parties upon request. The ~~Program shall~~ SLA will pay all transcript costs associated with the conduct of the hearing. (3-31-22)()

140. Report of Facts, Findings, Conclusion, and Recommended Decision. (3-31-22)

a. The hHearing oOfficer shall submit a report to the Administrator within twenty-one (21) calendar days after the hearing. This report ~~shall will~~ include: the issues and relevant facts adduced at the hearing; applicable provisions of law, rules, and ~~Commission~~ ICBVI policy; findings of fact and conclusions of law with respect to issues; and the reasons and basis thereof. (3-31-22)()

b. The report ~~shall~~ will also set forth any action necessary to resolve the issue and a recommended decision. (3-31-22)()

121. **Service of Report.** The report ~~shall~~ will be served ~~on~~ to the Administrator and all parties to the hearing. (3-31-22)()

132. **Written Comments, Arguments, and Exceptions.** Parties to the hearing may, within fifteen (15) ~~calendar~~ business days of the date the report was received in the Administrator's office, file written comments, arguments, and exceptions regarding factual or legal errors to the report with the Administrator. Comments, arguments, and exceptions received in a timely fashion become a part of the record and ~~shall~~ will be considered by the Administrator in making a final decision. (3-31-22)()

143. **Exclusive Record for Decision.** The transcript of testimony, exhibits, and ~~all papers and documents~~ any written comments, arguments, and exception to the report filed ~~shall~~ with the Administrator will constitute an exclusive record for decision. (3-31-22)()

154. **Decision.** The final decision of the Administrator ~~shall~~ will be mailed to the ~~v~~Vendor within thirty (30) ~~calender~~ days of receipt of the ~~h~~Hearing ~~e~~Officer's report. (3-31-22)()

191. -- 199. (RESERVED)

200. **ARBITRATION.**

If a Vendor is dissatisfied with a decision rendered after an ~~an~~ full-evidentiary hearing, the ~~v~~Vendor may request that an arbitration panel be convened by filing a complaint with the Secretary of the U.S. Department of Education in accordance with 34 CFR 395.13. (3-31-22)()

201. -- 209. (RESERVED)

210. **EXPLANATION TO VENDORS OF RIGHTS AND RESPONSIBILITIES.**

The ~~Program shall~~ SLA will furnish to each ~~v~~Vendor copies of documents relevant to the operation of the facility, in an accessible format including rules and procedures, a written description of the arrangements for providing services, the ~~agreement~~ OA and ~~p~~Permit covering the operation of the facility, and ~~shall~~ will provide explanation of these documents upon request by the ~~v~~Vendor. (3-31-22)()

211. -- ~~219~~. (RESERVED)

~~220~~. **DISCRIMINATION.**

The Program ~~shall not discriminate against any applicant, licensee or vendor on the basis of gender, race, age, creed, color, religion, physical or mental handicap, sexual orientation, or national origin.~~ (3-31-22)

~~221~~. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.10 – IDAHO REPORTABLE DISEASES

DOCKET NO. 16-0210-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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) 39-605, 39-906, 39-1003, 39-1603, 39-4505(2), 54-1119, 56-1003, and 56-1005, Idaho Code.

***EDITOR'S NOTE:** A correction has been made to an error that occurred during the publication of the proposed rulemaking under Docket No. 16-0210-2501 in the June 4, 2025, Idaho Administrative Bulletin, Volume 25-6. The error was not removing Subsection 460.04.b., which is sufficiently addressed by existing Idaho Code. The change to the pending rule described above was adopted by the agency and has been incorporated in the rule text of this docket. There were no additional changes to the pending rule. The Notice of Adoption of Pending Rule was published in the August 6, 2025, Idaho Administrative Bulletin, [Vol. 25-8, page 35](#). The complete text of the proposed rule was published in the June 4, 2025, Idaho Administrative Bulletin, [Vol. 25-6, pages 35 through 87](#).

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. 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 4th, 2025, Idaho Administrative Bulletin, [Vol. 25-6, pages 35 through 87](#).

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.

DATED this 8th day of July, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 39-605, 39-906, 39-1003, 39-1603, 39-4505(2), 54-1119, 56-1003, and 56-1005, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Monday, June 16, 2025 9:30 a.m. (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m61991eff4894a46b904e33d2c8527179
Join by meeting number Meeting number (access code): 2819 298 1764 Meeting password: xDhixiNB283 Meeting password when dialing from a phone or video system: 93449462
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)
Tuesday, June 17, 2025 9:30 a.m. (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=ma22c531f5534be954b1964170044d89a
Join by meeting number Meeting number (access code): 2822 181 7579 Meeting password: u7VPDppyP33 Meeting password when dialing from a phone or video system: 87873779
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)

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:

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 17 and 18](#).

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 Jared Larsen at DHWRules@dhw.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 June 25th, 2025.

DATED this 2nd day of May, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0210-2501

16.02.10 – IDAHO REPORTABLE DISEASES

000. LEGAL AUTHORITY.

Sections 39-605, 39-1003, 39-1603, and 56-1005, Idaho Code, grant authority to the Board of Health and Welfare to adopt rules protecting the health of the people of Idaho. Section 39-906, Idaho Code, provides for the Director to administer rules adopted by the Board of Health and Welfare. Section 39-4505(2), Idaho Code, gives the Director authority to promulgate rules regarding the identification of blood- or body fluid-transmitted viruses or diseases. Section 56-1003, Idaho Code, gives the Director the authority to adopt rules protecting the health of the people of Idaho and to recommend rules to the Board of Health and Welfare. Section 54-1119, Idaho Code, authorizes the Director to promulgate rules regarding the handling of dead human bodies as needed to preserve and protect the

public health. (3-17-22)

001. ~~TITLE AND SCOPE.~~

~~01. Title.~~ These rules are titled IDAPA 16.02.10, “Idaho Reportable Diseases.” (3-17-22)

~~02. Scope.~~ These rules contain the official requirements governing the reporting, control, and prevention of reportable diseases and conditions and requirements to prevent transmission of health hazards from dead human bodies. The purpose of these rules is to identify, control, and prevent the transmission of reportable diseases and conditions within Idaho. (3-17-22)()

002. DOCUMENTS INCORPORATED BY REFERENCE.

~~The documents referenced in Subsections 004.01 through 004.07 of this rule are used as a means of further clarifying these rules.~~ These documents are incorporated by reference and are available at the Idaho State Law Library or at the Department’s main office. (3-17-22)()

01. Guideline for Isolation Precautions in Hospitals. Siegel, J.D., et al., “Guideline for Isolation Precautions in Hospitals.” Health Care Infection Control Practices Advisory Committee, Atlanta, GA: Centers for Disease Control and Prevention, 2007. (3-17-22)

02. National Notifiable Diseases Surveillance System - Case Definitions. <http://ndc.services.cdc.gov/>. (3-17-22)

03. Human Rabies Prevention -- United States, 2008. Morbidity and Mortality Weekly Report, May 23, 2008, Vol. 57.RR-3. Centers for Disease Control and Prevention. (3-17-22)

04. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis. Infection Control and Hospital Epidemiology, September 2013, Vol. 34, 9. The Society for Healthcare Epidemiology of America. These guidelines are found online at <http://www.jstor.org/stable/10.1086/672271>. (3-17-22)

05. Compendium of Animal Rabies Prevention and Control, 2016. National Association of State Public Health Veterinarians, Inc., Journal of American Veterinary Medical Association Vol. 248(5), March 1, 2016. This document is found online at <http://nasphv.org/documentsCompendia.html>. (3-17-22)

06. Standards for Cancer Registries, Volume IVI, Data Standards and Data Dictionary. North American Association of Central Cancer Registries, ~~Eighteenth~~ Twenty-sixth Edition, Record Layout Version ~~14,~~ 25, January 2025. (3-17-22)()

07. Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices, 2010. Morbidity and Mortality Weekly Report, Recommendations and Reports, March 19, 2010/59(RR02);1-9. This document is found online at <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5902a1.htm>. (3-17-22)

~~003. DISCLOSURE OF INFORMATION.~~

~~No employee of the Department or Health District may disclose the identity of persons named in disease reports except to the extent necessary for the purpose of administering the public health laws of this state.~~ (3-17-22)

~~004~~3. -- 009. (RESERVED)

010. DEFINITIONS A THROUGH K.

For the purposes of this chapter, the following definitions apply. (3-17-22)

~~01. Airborne Precautions.~~ Methods used to prevent airborne transmission of infectious agents, as described in “Guideline for Isolation Precautions in Hospitals,” incorporated in Section 004 of these rules. (3-17-22)

021. Approved Fecal Specimens. Specimens of feces obtained from the designated person who has not

taken any antibiotic orally or parenterally for two (2) days prior to the collection of the fecal specimen. The specimen must be collected and transported to the laboratory in a manner appropriate for the test to be performed. (3-17-22)

032. Bite or Other Exposure to Rabies. Bite or bitten means that the skin of the person or animal has been nipped or gripped, or has been wounded or pierced, including scratches, and includes probable contact of saliva with a break or abrasion of the skin. The term “exposure” also includes contact of saliva with any mucous membrane. In the case of bats, even in the absence of an apparent bite, scratch, or mucous membrane contact, exposure may have occurred, as described in “Human Rabies Prevention -- United States,” ~~incorporated in Section 004 of these rules.~~ (3-17-22)()

043. Board. The Idaho State Board of Health and Welfare ~~as described in Section 56-1005, Idaho Code.~~ (3-17-22)()

054. Cancer Data Registry of Idaho (CDRI). The agency performing cancer registry services under a contractual agreement with the Department as described in Section 57-1703, Idaho Code. (3-17-22)

06. Cancers. ~~Cancers that are designated reportable include the following as described in Section 57-1703, Idaho Code:~~ (3-17-22)

a. ~~In-situ or malignant neoplasms, but excluding basal cell and squamous cell carcinoma of the skin unless occurring on a mucous membrane and excluding in-situ neoplasms of the cervix.~~ (3-17-22)

b. ~~Benign tumors of the brain, meninges, pineal gland, or pituitary gland.~~ (3-17-22)

075. Carrier. ~~A carrier is a~~ person who can transmit a communicable disease to another person, but may not have symptoms of the disease. (3-17-22)()

086. Case. (3-17-22)

a. ~~A person, who has been diagnosed as having a specific disease or condition by a physician or other health care provider, is considered a case.~~ The diagnosis may be based on clinical judgment, on laboratory evidence, or on both criteria. ~~Individual case definitions are described in “National Notifiable Diseases Surveillance System Case Definitions,” incorporated in Section 004 of these rules.~~ will be evaluated for public health case classification. (3-17-22)()

b. ~~A laboratory detection of a disease or condition as listed in Section 050 of these rules and as further outlined in Sections 100 through 949 of these rules.~~ (3-17-22)

09. Cohort System. ~~A communicable disease control mechanism in which cases having the same disease are temporarily segregated to continue to allow supervision and structured attendance in a daycare or health care facility.~~ (3-17-22)

107. Communicable Disease. A disease that may be transmitted from one (1) person or an animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means that may result in infection, illness, disability, or death. (3-17-22)

108. Contact. ~~A contact is a~~ person who has been exposed to a case or a carrier of a communicable disease while the disease was communicable, or a person by whom a case or carrier of a communicable disease could have been exposed to the disease. (3-17-22)()

12. Contact Precautions. ~~Methods used to prevent contact transmission of infectious agents, as described in the “Guideline for Isolation Precautions in Hospitals,” incorporated in Section 004 of these rules.~~ (3-17-22)

1309. Daycare. ~~Care and supervision provided for compensation during part of a twenty-four (24) hour day, for a child or children not related by blood or marriage to the person or persons providing the care, in a place other than the child’s or children’s own home or homes~~ as described by Section 39-1102, Idaho Code.

(3-17-22)()

1410. Department. The Idaho Department of Health and Welfare or its designee. (3-17-22)

1511. Director. The Director of the Idaho Department of Health and Welfare or their designee ~~as described under Sections 56-1003 and 39-414(2), Idaho Code, and Section 950 of these rules.~~ (3-17-22)()

1612. Division of Public Health Administrator. A person appointed by the Director to oversee the administration of the Division of Public Health, Idaho Department of Health and Welfare, or their designee. (3-17-22)

17. Droplet Precautions. ~~Methods used to prevent droplet transmission of infectious agents, as described in the “Guideline for Isolation Precautions in Hospitals,” incorporated in Section 004 of these rules.~~ (3-17-22)

18. Exclusion. ~~An exclusion for a food service facility means a person is prevented from working as a food employee or entering a food establishment except for those areas open to the general public as outlined in the IDAPA 16.02.19, “Idaho Food Code.”~~ (3-17-22)

1913. Extraordinary Occurrence of Illness Including Clusters. Rare or novel diseases and unusual outbreaks of illness that may be a risk to the public ~~are considered an extraordinary occurrence of illness. Even in the absence of a defined etiologic agent or toxic substance, clusters of unexplained acute illness and early stage disease symptoms.~~ Illnesses related to drugs, foods, contaminated medical devices, contaminated medical products, illnesses related to environmental contamination by infectious or toxic agents, unusual syndromes, or illnesses associated with occupational exposure to physical or chemical agents may be included in this definition. (3-17-22)()

2014. Fecal Incontinence. A condition in which temporarily, as with severe diarrhea, or long-term, as with a child or adult requiring diapers, there is an inability to hold feces in the rectum, resulting in involuntary voiding of stool. (3-17-22)

2115. Foodborne Disease Outbreak. ~~An outbreak is when t~~ Two (2) or more persons experiencing a similar illness after ingesting a common food, and epidemiological investigation indicates food as the source of the illness. (3-17-22)()

2216. Food Employee. An individual working with unpackaged food, food equipment or utensils, or food-contact surfaces as defined in IDAPA 16.02.19, “Idaho Food Code.” (3-17-22)

2317. Health Care Facility. An establishment organized and operated to provide health care to three (3) or more individuals who are not members of the immediate family. This definition includes hospitals, intermediate care facilities, residential care and assisted living facilities. (3-17-22)

2418. Health Care Provider. A person who has direct or supervisory responsibility for the delivery of health care or medical services. ~~This includes: licensed physicians, nurse practitioners, physician assistants, nurses, dentists, chiropractors, and administrators, superintendents, and managers of clinics, hospitals, and licensed laboratories.~~ (3-17-22)()

2519. Health District. Any one (1) of the seven (7) public health districts as established by Section 39-409, Idaho Code, ~~and described in Section 030 of these rules.~~ (3-17-22)()

260. Health District Director. Any one (1) of the public health districts’ directors appointed by the Health District’s Board as described in Section 39-413, Idaho Code, or their designee. (3-17-22)

271. Idaho Food Code. Idaho Administrative Code that governs food safety, IDAPA 16.02.19, “Idaho Food Code.” ~~These rules may be found online at <http://adminrules.idaho.gov/rules/current/16/160219.pdf>.~~ (3-17-22)()

22. Investigation. Public health methods used to determine exposure source, risk factors, susceptible

contacts, transmission risks, and prevention measures necessary to limit additional cases of a disease or condition. Investigations may be individual case investigations or epidemiologic investigations of more than one illness. ()

283. Isolation. The separation of a person known or suspected to be infected with an infectious agent, or contaminated from chemical or biological agents, from other persons to such places, under such conditions, and for such time as will prevent transmission of the infectious agent or further contamination. ~~The place of isolation will be designated by the Director under Section 56-1003(7), Idaho Code, and Section 065 of these rules.~~ (3-17-22)()

011. DEFINITIONS L THROUGH Z.

For the purposes of this chapter, the following definitions apply. (3-17-22)

01. Laboratory Director. A person ~~who is~~ directly responsible for the operation of a licensed laboratory or their designee. (3-17-22)()

02. Laboratory. A medical diagnostic laboratory that is inspected, licensed, or approved by the Department or licensed according to the provisions of the Clinical Laboratory Improvement Act by the United States Health Care and Financing Administration. Laboratory may also refer to the Idaho State Public Health Laboratory, and to the United States Centers for Disease Control and Prevention. (3-17-22)

03. Livestock. Livestock as defined by the Idaho Department of Agriculture in IDAPA 02.04.03, “Rules Governing Animal Industry.” (3-17-22)

04. Medical Record. Hospital or medical records ~~are all those records~~ compiled for the purpose of recording a medical history, diagnostic studies, laboratory tests, treatments, or rehabilitation. ~~Access will be limited to those parts of the record that will provide a diagnosis, or will assist in identifying contacts to a reportable disease or condition. Records specifically exempted by statute are not reviewable.~~ (3-17-22)()

05. Outbreak. An ~~outbreak is an~~ unusual rise in the incidence of a disease. An outbreak may consist of a single case. (3-17-22)(3-17-22)

06. Personal Care. The service provided by one (1) person to another for the purpose of feeding, bathing, dressing, assisting with personal hygiene, changing diapers, changing bedding, and other services involving direct physical contact. (3-17-22)

07. Physician. A person ~~legally authorized to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho~~ as defined in Section 54-1803, Idaho Code. (3-17-22)(3-17-22)

08. Quarantine. The restriction placed on ~~the entrance to and exit from the place or premises where an infectious agent or hazardous material exists. The place of quarantine will be designated by the Director or Health District Board~~ a person exposed to an infectious or communicable disease, to a person displaying unknown symptoms, or to a contamination from a chemical, nuclear, or biological agent as defined in Section 56-1003, Idaho Code. (3-17-22)()

09. Rabies Post-Exposure Prophylaxis (rPEP). The administration of a rabies vaccine series with or without the antirabies immune globulin, depending on pre-exposure vaccination status, following a documented or suspected rabies exposure, ~~as described in “Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices,” incorporated in Section 004 of these rules.~~ (3-17-22)()

10. Rabies Susceptible Animal. Any animal capable of being infected with the rabies virus. (3-17-22)

140. Residential Care Facility. A ~~commercial or non-profit establishment organized and operated to provide a place of residence for three (3) or more individuals who are not members of the same family, but live within the same household. Any restriction for this type of facility is included under restrictions for a health care facility facility as defined in 39-3302(27), Idaho Code.~~ (3-17-22)()

121. Restriction. (3-17-22)

~~a. To limit the activities. The limitation~~ of a person's activities to reduce the risk of transmitting a communicable disease. ~~Activities of individuals are restricted or limited to reduce the risk of disease transmission until such time that they are no longer considered a health risk to others.~~ (3-17-22)()

~~b. A food employee who is restricted must not work with exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles. A restricted employee may still work at a food establishment as outlined in the IDAPA 16.02.19, "Idaho Food Code."~~ (3-17-22)

132. Restrictable Disease. A ~~restrictable disease is a~~ communicable disease, which if left unrestricted, may have serious consequences to the public's health. The determination of whether a disease is restrictable is based upon the specific environmental setting and the likelihood of transmission to susceptible persons. (3-17-22)()

143. Severe Reaction to Any Immunization. Any serious or life-threatening condition that results directly from the administration of any immunization against a communicable disease. (3-17-22)

154. Significant Exposure to Blood or Body Fluids. ~~Significant exposure is defined as a~~ A percutaneous injury, contact of mucous membrane or non-intact skin, or contact with intact skin when the duration of contact is prolonged or involves an extensive area, with blood, tissue, or other body fluids as defined in "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis," ~~incorporated in Section 004 of these rules.~~ (3-17-22)()

16. Standard Precautions. Methods used to prevent transmission of all infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," ~~incorporated in Section 004 of these rules.~~ (3-17-22)

175. State Epidemiologist. A person employed by the Department to serve as a statewide epidemiologist or their designee. (3-17-22)

186. Suspected Case. A person diagnosed with or thought to have a particular disease or condition by a licensed physician or other health care provider. ~~The suspected diagnosis may be based on signs and symptoms, or on laboratory evidence, or both criteria. Suspected cases of some diseases are reportable as described in Section 050 of these rules. Public health suspected case definitions are described in "National Notifiable Diseases Surveillance System Case Definitions."~~ (3-17-22)()

19. Vaccination of an Animal Against Rabies. Vaccination of an animal by a licensed veterinarian with a rabies vaccine licensed or approved for the animal species and administered according to the specifications on the product label or package insert as described in the "Compendium of Animal Rabies Prevention and Control," ~~incorporated in Section 004 of these rules.~~ (3-17-22)

2017. Veterinarian. Any ~~licensed veterinarian~~ individual as defined in Section 54-2103, Idaho Code. (3-17-22)()

2418. Waterborne Outbreak. ~~An outbreak is when t~~ Two (2) or more persons ~~experience with~~ a similar illness after exposure to water from a common source and ~~an epidemiological analysis implicates the evidence indicates~~ water as the source of the illness. (3-17-22)()

2219. Working Day. ~~A working day is from 8 a.m. to 5 p.m., Monday through Friday, excluding state holidays~~ As defined in 48-1002(1), Idaho Code. (3-17-22)()

012. -- 019. (RESERVED)

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

01. Physician. A licensed physician who diagnoses, treats, or cares for a person with a reportable disease or condition must ~~make a report of such the~~ disease or condition to the Department or Health District ~~as~~

~~described in these rules.~~ The physician is also responsible for reporting diseases and conditions diagnosed or treated by ~~physician assistants, nurse practitioners, or others~~ anyone under the physician's supervision. (3-17-22)()

02. Hospital or Health Care Facility Administrator. The hospital or health care facility administrator must report all persons who are diagnosed, treated, or receive care for a reportable disease or condition in their facility unless the attending physician has reported the disease or condition. (3-17-22)

03. Laboratory Director. The laboratory director must report to the Department or Health District the identification of, or laboratory findings suggestive of, the presence of the organisms, diseases, or conditions listed in ~~Section 050~~ of these rules. (3-17-22)()

04. School Administrator. A school administrator must report diseases and conditions to the Department or Health District ~~as indicated in Section 050 of these rules.~~ A school administrator must report the closure of any public, parochial, charter, or private school within one (1) working day when, in their opinion, such closing is related to a communicable disease. (3-17-22)()

05. Persons in Charge of Food Establishments. A person in charge of an eating or drinking establishment must report diseases and conditions to the Department or Health District ~~as indicated in Section 050 of these rules and obtain guidance on proper actions needed to protect the public.~~ (3-17-22)()

06. Others Required to Report Reportable Diseases. In addition to licensed physicians, reports must also be made by ~~physician assistants, certified nurse practitioners, licensed registered nurses, school health nurses, infection surveillance staff, public health officials, and~~ coroners and other health care providers as described in 39-7702, Idaho Code. (3-17-22)()

021. ACCESS TO MEDICAL RECORDS.

No physician, hospital administrative person, or patient may deny the Department, Health Districts, or the Board access to medical records in discharge of their duties in implementing the reportable disease rules. (3-17-22)

~~**022. PENALTY PROVISIONS.**~~

~~These rules may be enforced under the civil and criminal penalties described in Sections 39-108, 39-109, 39-607, 39-1006, 39-1606, and 56-1008, Idaho Code, and other applicable statutes and rules. Penalties may include fines and imprisonment as specified in Idaho Code.~~ (3-17-22)

~~**023. DELEGATION OF POWERS AND DUTIES.**~~

~~The Director has the authority to delegate to the Health Districts any of the powers and duties created by these rules under Section 39-414(2), Idaho Code. Any delegation authority will be in writing and signed by the both the Director and the Health District Board.~~ (3-17-22)

~~**024**~~. -- 029. (RESERVED)

030. WHERE TO REPORT REPORTABLE DISEASES AND CONDITIONS.

~~Subsections 030.01 through 030.09 of this rule provide where information for reporting of suspected, identified, and diagnosed diseases and conditions are to be reported. The diseases and conditions in Sections 100 through 949 of these rules are reportable to the agencies listed in Subsections 030.01 through 030.09 of this rule.~~ (3-17-22)

01. Department of Health and Welfare, Bureau of Environmental Health and Communicable Disease ~~Prevention~~ Epidemiology Program. (3-17-22)()

a. Main Office Address: 450 West State Street, 4th Floor, Boise, ID 83720. (3-17-22)

b. Phone: (208) 334-5939 and FAX: (208) 332-7307. (3-17-22)

02. Health District I - Panhandle Health District. The Panhandle Health District covers the counties of Benewah, Bonner, Boundary, Kootenai, and Shoshone. (3-17-22)

a. Main Office Address: 8500 N. Atlas Road, Hayden, ID 83835. (3-17-22)

- b. Phone: (208) 772-3920 and FAX: 1-866-716-2599 Toll Free. (3-17-22)
- 03. Health District II - Public Health Idaho North Central District.** The North Central District covers the counties of Clearwater, Idaho, Latah, Lewis, and Nez Perce. (3-17-22)
- a. Main Office Address: 215 10th Street, Lewiston, ID 83501. (3-17-22)
- b. Phone: (208) 799-3100 and FAX: (208) 799-0349. (3-17-22)
- 04. Health District III - Southwest District Health.** Southwest District Health covers the counties of Adams, Canyon, Gem, Owyhee, Payette, and Washington. (3-17-22)
- a. Main Office Address: 13307 Miami Lane, Caldwell, ID 83607. (3-17-22)
- b. Phone: (208) 455-5442 and FAX: (208) 455-5350. (3-17-22)
- 05. Health District IV - Central District Health—~~Department~~.** The Central District Health ~~Department~~ covers the counties of Ada, Boise, Elmore and Valley. (3-17-22)()
- a. Main Office Address: 707 N. Armstrong Place, Boise, ID 83704. (3-17-22)
- b. Phone: (208) 327-8625 and FAX: (208) 327-7100. (3-17-22)
- 06. Health District V - South Central Public Health District.** The South Central Public Health District covers the counties of Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls. (3-17-22)
- a. Main Office Address: 1020 Washington Street N., Twin Falls, ID 83301. (3-17-22)
- b. Phone: (208) 737-5929 and FAX: (208) 736-3009. (3-17-22)
- 07. Health District VI - Southeastern Idaho Public Health.** The Southeastern Idaho Public Health District covers the counties of Bannock, Bear Lake, Bingham, Butte, Caribou, Franklin, Oneida, and Power. (3-17-22)
- a. Main Office Address: 1901 Alvin Ricken Drive, Pocatello, ID 83201. (3-17-22)
- b. Phone: (208) 233-9080 and FAX: (208) 233-1916. (3-17-22)
- 08. Health District VII - Eastern Idaho Public Health—~~District~~.** The Eastern Idaho Public Health ~~District~~ covers the counties of Bonneville, Clark, Custer, Fremont, Jefferson, Lemhi, Madison and Teton. (3-17-22)()
- a. Main Office Address: 1250 Hollipark Drive, Idaho Falls, ID 83401. (3-17-22)
- b. Phone: (208) 533-3152 and FAX: (208) 523-4365. (3-17-22)
- 09. Cancer Data Registry of Idaho (CDRI).** (3-17-22)
- a. Main Office Address: 615 N. 7th Street, P.O. Box 1278, Boise, ID 83701. (3-17-22)
- b. Phone: (208) 338-5100. (3-17-22)
- 10. ~~Inter-Agency Notification.~~** The Health District must notify the Department of reportable diseases and conditions as listed in Section 050 of these rules. (3-17-22)

~~a.~~ The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case of a reportable disease or condition when required in Sections 100 through 949 of these rules. (3-17-22)

~~b.~~ The Department and the Health District will exchange reported information no later than weekly of all other cases of reportable diseases and conditions. (3-17-22)

~~c.~~ The Department will notify the Idaho Department of Agriculture of any identified or suspected source of an animal related disease when required in Sections 100 through 949 of these rules. (3-17-22)

031. -- 039. (RESERVED)

040. REPORT CONTENTS AND ~~METHOD OF~~ AFTER-HOURS REPORTING.

- 01. Report Contents.** Each report of a reportable disease or condition must include: (3-17-22)
- a.** The identity and address of the attending licensed physician or the person reporting; (3-17-22)
 - b.** The diagnosed or suspected disease or condition; (3-17-22)
 - c.** The name, current address, telephone number, birth date, age, race, ethnicity, and sex of the individual with the disease or other identifier from whom the specimen was obtained; (3-17-22)
 - d.** The date of onset of the disease or the date the test results were received; and (3-17-22)
 - e.** In addition, laboratory directors must report the identity of the organism or other significant test result. (3-17-22)

~~**02. How To Report.** A report of a case or suspected case may be made to the Department or Health District by telephone, mail, fax, or through electronic disease reporting systems as listed in Section 030 of these rules. (3-17-22)~~

~~**032. After Hours Notification.** An after hours report of a disease or condition may be made through the Idaho State EMS Communications Center (State Comm) at (800) 632-8000. A public health official will be contacted regarding the report. (3-17-22)()~~

041. -- 049. (RESERVED)

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

Reportable diseases and conditions must be reported to the Department or Health District ~~by those required under Section 020 of these rules and must be investigated to confirm the diagnosis, obtain specific clinical information, determine possible risk factors, identify clusters or outbreaks of the infection, and identify the source of infection.~~ The table below identifies the reportable and restrictable diseases and conditions, the timeframe for reporting, and the person or facility required to report. ~~Restrictions, unless otherwise specified, are for the duration of time that the disease is in a communicable form, other than for Food Employees with Food Service restrictable conditions, who must be managed under IDAPA 16.02.19, "Idaho Food Code".~~

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	Section-in-Rule	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)
~~Acquired Immune Deficiency Syndrome (AIDS), (including CD-4 lymphocyte counts <200 cells/mm³ blood or <14%)~~	~~400~~	~~Within 3 working days~~	~~None~~	
Amebiasis and Free-living Amebae	410	Within 3 working days	DC, FS, HC	Food Service Facility
Anthrax (<i>Bacillus anthracis</i>)	420	Immediately	None	
Arboviral Diseases, <u>including suspected cases</u>	425	Within 3 working days	None	
~~Biotinidase Deficiency~~	~~430~~	~~Within 1 working day (in newborn screening)~~	~~None~~	
Botulism, <u>including suspected cases</u>	440	Immediately	None	
Brucellosis (<i>Brucella</i> species)	450	Within 1 working day	None	
Campylobacteriosis (<i>Campylobacter</i> species)	460	Within 3 working days	DC, FS, HC	Food Service Facility
Cancer	470	Report to Cancer Data Registry of Idaho within 180 days of diagnosis or recurrence (including suspected cases)	None	
Chancroid	480	Within 3 working days	None	
<i>Chlamydia trachomatis</i> Infections	490	Within 3 working days	HC - ophthalmia neonatorum only	
Cholera (<i>Vibrio cholerae</i>)	200	Within 1 working day	FS, HC, DC	Food Service Facility
~~Congenital Hypothyroidism~~	~~210~~	~~Within 1 working day (in newborn screening)~~	~~None~~	
Conjunctivitis	080, 090	No reporting required	DC, S	
Cryptosporidiosis (<i>Cryptosporidium</i> species)	220	Within 3 working days	FS, HC, DC	
Cutaneous Fungal Infections	080, 090	No reporting required	DC, S	
Diarrhea (until common communicable diseases have been ruled out)	085	No reporting required	FS	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	Section in Rule	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)
Diphtheria (<i>Corynebacterium diphtheriae</i>)	230	Immediately	DC, FS, HC, S	School
Echinococcosis	235	Within 3 working days	None	
Encephalitis, Viral or Aseptic	240	Within 3 working days	None	
<i>Escherichia coli</i> O157:H7 and other Shiga-Toxin Producing <i>E. coli</i> (STEC)	250	Within 1 working day	DC, FS, HC	Food Service Facility School
Extraordinary Occurrence of Illness, including Clusters	260	Within 1 working day	None	
Fever	085	No reporting required	FS	
Food Poisoning, Foodborne Illness, and Waterborne Illnesses, including suspected cases and outbreaks	270	Within 1 working day	None	
Galactosemia	280	Within 1 working day (in newborn screening)	None	
Giardiasis (<i>Giardia lamblia</i>)	290	Within 3 working days	DC, FS, HC	Food Service Facility
<i>Haemophilus influenzae</i> Invasive Disease	300	Within 1 working day	DC, S	School
Hantavirus Pulmonary Syndrome	340	Within 1 working day	None	
Hemolytic-Uremic Syndrome (HUS) or Thrombotic thrombocytopenic purpura-HUS (TTP-HUS)	320	Within 1 working day	None	
Hepatitis A	330	Within 1 working day	DC, FS, HC	Food Service Facility
Hepatitis B	340	Within 1 working day	None	
Hepatitis C	350	Within 3 working days	None	
Human Immunodeficiency Virus (HIV)	360	Within 3 working days	None	
Human T-Lymphotropic Virus	370	Within 3 working days	None	
Jaundice	085	No reporting required	FS	
Lead Poisoning	380	Within 3 working days	None	
Legionellosis	390	Within 3 working days	None	
Leprosy (Hansen's Disease)	400	Within 3 working days	None	
Leptospirosis	440	Within 3 working days	None	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	Section in Rule	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)
Listeriosis (<i>Listeria</i> species)	420	Within 3 working days	None	
Lyme Disease	430	Within 3 working days	None	
Malaria (<i>Plasmodium</i> species)	440	Within 3 working days	None	
Maple Syrup Urine Disease	450	Within 1 working day (in newborn screening)	None	
Measles (Rubeola)	460	Within 1 working day	DC, HC, S	School
Meningitis, Viral or Aseptic	470	Within 3 working days	None	
Methicillin-resistant (MRSA and Vancomycin-resistant (VRSA) <i>Staphylococcus aureus</i> (MRSA) Invasive Disease	475	Within 3 working days	None	Note: Only Laboratory Directors need to report.
Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Non-Invasive Disease	475, 080, 090	No reporting required	DC, FS, HC, S	
Mumps	480	Within 3 working days	DC, S, HC	School
Myocarditis, Viral	490	Within 3 working days	None	
<i>Neisseria gonorrhoeae</i> Infections	500	Within 3 working days	HC-ophthalmia neonatorum only	
<i>Neisseria meningitidis</i> Invasive Disease	510	Within 1 working day	DC, HC, S	School
Norovirus	520	Within 1 working day	DC, FS, HC, S	
Novel Influenza A Virus	522	Within 1 working day	DC, FS, HC, S	
Pediculosis	080, 090	No reporting required	DC, S	
Pertussis (<i>Bordetella pertussis</i>)	530	Within 1 working day	DC, HC, S	School
Phenylketonuria (PKU)	540	Within 1 working day (in newborn screening)	None	
Plague (<i>Yersinia pestis</i>)	550	Immediately	HC, S	School
Pneumococcal Invasive Disease in Children less than Eighteen (18) Years of Age (<i>Streptococcus pneumoniae</i>)	560	Within 3 working days	DC, S	School
<i>Pneumocystis</i> Pneumonia (PCP)	570	Within 3 working days	None	
Poliomyelitis	580	Within 1 working day	DC	School
Psittacosis	590	Within 3 working days	None	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	Section in Rule	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)
Q Fever	600	Within 1 working day	None	
Rabies - Human, Animal, and Post-Exposure Prophylaxis (rPEP)	640	Immediately (human), Within 1 working day (animal or rPEP)	None	
Relapsing Fever, Tick-borne and Louse-borne	620	Within 3 working days	None	
Respiratory Syncytial Virus (RSV)	630	Within 1 working day	None	Note: Only Laboratory Directors need to report.
~~Reye Syndrome~~	640	~~Within 3 working days~~	~~None~~	
~~Rocky Mountain~~ Spotted Fever, ~~Rickettsiosis~~	650	Within 3 working days	None	
Rubella (including Congenital Rubella Syndrome)	660	Within 1 working day	DC, HC, S	School
Salmonellosis (including Typhoid Fever) (<i>Salmonella</i> species)	670	Within 1 working day	DC, FS, HC	Food Service Facility
Scabies	~~080, 090~~	No reporting required	DC, S	
Severe Acute Respiratory Syndrome (SARS), <u>including suspected cases</u>	680	Within 1 working day	DC, S	School
Severe Reaction to Any Immunization	690	Within 1 working day	None	
Shigellosis (<i>Shigella</i> species)	700	Within 1 working day	DC, FS, HC, S	Food Service Facility School
Smallpox, <u>including suspected cases</u>	740	Immediately	DC, HC, S	School
Sore Throat with Fever	~~085~~	No reporting required	FS	
Staphylococcal Infections other than MRSA	~~080, 085, 090~~	No reporting required	DC, FS, S	
Streptococcal Pharyngeal Infections	~~080, 090~~	No reporting required	DC, S	
<i>Streptococcus pyogenes</i> (group A strep), Invasive or Resulting in Rheumatic Fever	720	Within 3 working days	DC, HC, S	School
Syphilis	730	Within 3 working days	None	
Taeniasis	085	No reporting required	FS	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	Section in Rule	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)
Tetanus	740	Within 3 working days	None	
Toxic Shock Syndrome	750	Within 3 working days	None	
Transmissible Spongiform Encephalopathies (TSE), including Creutzfeldt-Jakob Disease (CJD) and Variant CJD (vCJD)	760	Within 3 working days	None	
Trichinosis	770	Within 3 working days	None	
Tuberculosis (<i>Mycobacterium tuberculosis</i>)	780	Within 3 working days	DC, FS, HC, S	School Food Service Facility
Tularemia (<i>Francisella tularensis</i>)	790	Immediately; Identification of <i>Francisella tularensis</i> - within 1 working day	None	
Uncovered and Open or Draining Skin Lesions with Pus, such as a Boil or Open Wound	085	No reporting required	FS	
Varicella (chickenpox)	080, 090	No reporting required	DC, S	
<u>Viral Hemorrhagic Fever</u>		<u>Immediately</u>	<u>DC, FS, HC, S</u>	
Vomiting (until noninfectious cause is identified)	085	No reporting required	FS	
Yersiniosis (<i>Yersinia enterocolitica</i> and <i>Yersinia pseudotuberculosis</i>)	840	Within 3 working days; Identification of <i>Yersinia pestis</i> - immediately	FS	

(3-17-22)()

~~051. — 059.~~ (RESERVED)

~~060. TESTING FOR CERTAIN REPORTABLE DISEASES WHEN INFORMED CONSENT IS NOT POSSIBLE.~~

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

(3-17-22)

~~061-51.~~ -- 064. (RESERVED)

065. INVESTIGATION AND CONTROL OF REPORTABLE DISEASES.

01. Responsibility and Authority. The Department will use all reasonable means to confirm in a

timely manner any case or suspected case of a reportable disease or condition, and will determine, when possible, all sources of infection and the extent of exposure. ~~Reports of diseases and conditions enumerated in this chapter will be investigated.~~ Investigations may be made when the ~~Division of Public Health Administrator, Health District Director, or state epidemiologist~~ Department or Health District determines a disease to be of public health significance. (3-17-22)()

a. Every licensed physician or other health care provider attending to a person with a reportable disease or condition must ~~report the case or suspected case, as described in Section 050 of these rules. They must instruct~~ inform the person on applicable control measures as outlined in ~~Sections 100 through 949 of these rules and~~ cooperate with the Department in the investigation and control of the disease or condition. (3-17-22)()

b. Any person providing emergency or medical services who believes they have experienced a significant exposure to blood or bodily fluids ~~as defined in Subsection 011.15 of these rules~~ may report said exposure as soon as possible ~~or within fourteen (14) days of the occurrence~~ to the Department ~~on a significant exposure report form~~. When, ~~in the state epidemiologist's judgment,~~ judges a significant exposure has occurred, the Department will inform the exposed individual that they may have been exposed to the HIV or HBV virus, or that there is no information available based on the Department's current HIV or HBV registry and will recommend appropriate counseling and testing for the exposed individual. (3-17-22)()

02. ~~Inspection—Right of Entry.~~ The Department may enter private or public property for the purpose of administering or enforcing the provisions of these rules under the authority and constraints granted by Section 56-1009, Idaho Code. (3-17-22)

032. **Inviolability of Placards.** If it is necessary to use placards, it is unlawful for any person to interfere with, conceal, mutilate or tear down any notices or placards on any house, building or premises placed by the Department. Such placards can only be removed by the health official. (3-17-22)

043. **Verification of Diagnosis and Case Classification.** Cases of diseases or conditions reported to the Department will be treated as such upon the statement of the attending licensed physician or other health care provider, unless there is reason to doubt the diagnosis. Final decision as to the ~~diagnosis case classification~~ for administrative purposes will rest with the Division of Public Health Administrator or Health District Director. (3-17-22)()

054. **Closure of Schools and Places of Public Assembly.** The Director may order the closing of any public, parochial, or private school, or other place of public assembly when, in their opinion, such closing is necessary to protect public health. The school or other place of public assembly must not reopen until permitted by the health official. (3-17-22)

065. **Transportation of Patients With Communicable Disease.** No person with a reportable disease in a communicable form, who is under orders of isolation, nor any contact who is restricted under an order of quarantine, may travel or be transported from one place to another without the permission of the Division of Public Health Administrator or Health District Director. An exception may be made in instances where the patient ~~is to~~ will be admitted directly to a hospital or treatment facility, provided adequate precautions are taken to prevent ~~dissemination~~ transmission of the disease by the patient enroute to the hospital or treatment facility. (3-17-22)()

076. **Order to Report for Examination.** The Division of Public Health Administrator or Health District Director may issue an order to report for examination. An order to report for examination must be served by delivering one (1) copy to the person to be examined, one (1) copy to the prosecuting attorney of the county or city in which the person resides, and filing one (1) copy bearing the notation of time and place of service and the signature of the person serving the notice with the issuing health authority. (3-17-22)

087. **Order for Isolation.** The Division of Public Health Administrator or Health District Director may issue and withdraw an order for isolation if they determine that it is necessary to protect the public from a significant risk of the spread of infectious or communicable diseases or from contamination from chemical or biological agents. ~~Orders for isolation must be executed as described in Subsections 065.08.a. and 065.08.b. of this rule.~~ (3-17-22)()

- a. The order for isolation must be executed as follows: (3-17-22)
 - i. One (1) copy to the individual being isolated; (3-17-22)
 - ii. One (1) copy to the attending licensed physician; (3-17-22)
 - iii. One (1) copy to the prosecuting attorney of the county or city in which the person resides; and (3-17-22)
 - iv. One (1) copy to be filed in the office of the issuing officer along with an affidavit of service signed by the person who served the order. (3-17-22)

b. The issuing officer will make an assessment and identify the least restrictive means of isolation that effectively protects unexposed and susceptible individuals from the public health threat. Orders of isolation require the individual to isolate himself at a certain place or places, and may require specific precautions to be taken when outside a designated place of isolation as the issuing officer deems appropriate and necessary. If the place of isolation is other than the individual's place of residence, a copy of the order must be provided to the person in charge of that place. (3-17-22)

c. The Division of Public Health Administrator or Health District Director will withdraw an order for isolation once it is determined there is no longer a significant threat to the public's health posed by the individual under order for isolation. (3-17-22)

098. Order for Quarantine. The Division of Public Health Administrator or Health District Director is empowered whenever a case of any communicable disease occurs in any household or other place within their jurisdiction and in their opinion it is necessary that persons residing within must be kept from contact with the public, to ~~declare the house, building, apartment, or room a place of quarantine and to~~ require that no persons will leave or enter during the period of quarantine except with specific permission of the issuing officer. ~~Orders for quarantine must be executed as described in Subsections 065.09.a. and 065.09.b. of this rule.~~ (3-17-22)()

- a. The order for quarantine must be executed as follows: (3-17-22)
 - i. One (1) copy to any individual being quarantined; (3-17-22)
 - ii. One (1) copy to the attending licensed physician; (3-17-22)
 - iii. One (1) copy to the prosecuting attorney of the county or city in which the quarantine occurs; (3-17-22)
 - iv. One (1) copy to be filed in the office of the issuing officer along with an affidavit of service signed by the person who served the order; and (3-17-22)
 - v. One (1) copy to the person in charge or owner of the place of quarantine. (3-17-22)

b. The issuing officer will make an assessment and identify the least restrictive timeframe of quarantine that effectively protects unexposed and susceptible individuals to the infection of public health threat. (3-17-22)

c. The Division of Public Health Administrator or Health District Director will withdraw an order for quarantine when they determine there is no longer a significant threat to the public's health posed by the individual or premises under the order for quarantine. (3-17-22)

409. Sexually Transmitted Infection Contacts. Any person infected with a sexually transmitted infection (venereal disease) as defined in Section 39-601, Idaho Code, is required to provide the name, address, and telephone number(s) of all persons from whom the disease may have been acquired and to whom the disease may have been transmitted, when such information is requested by the Department or Health District. (3-17-22)

066. -- 067. (RESERVED)

068. PREVENTING SPREAD OF HEALTH HAZARDS FROM DEAD HUMAN BODIES.

01. Embalming. (3-17-22)

a. The Division of Public Health Administrator or Health District Director may order a dead human body to be embalmed or prohibit embalming to prevent the spread of infectious or communicable diseases or exposure to hazardous substances. (3-17-22)

b. The dead human body of a person suspected of or confirmed as having a viral hemorrhagic fever at the time of death must not be embalmed, but wrapped in sealed leak-proof material and cremated or buried. (3-17-22)

02. Burial. The Division of Public Health Administrator or Health District Director may order a dead human body to be buried or cremated, or prohibit burial or cremation, and may specify a time frame for final disposition to prevent the spread of infectious or communicable diseases or exposure to hazardous substances. ~~As required in Section 39-268, Idaho Code, all orders of cremation will be approved by the coroner and the coroner will be notified of prohibitions of cremation ordered by the Administrator or Director.~~ (3-17-22)()

03. Notification of Health Hazard. Any person authorized to release a dead human body of a person suspected of or confirmed as having a prior disease, a viral hemorrhagic fever, other infectious health hazard, or contaminated with a hazardous substance, must notify the person taking possession of the body and indicate necessary precautions on a written notice to accompany the body. (3-17-22)

069. (RESERVED)

070. SPECIAL DISEASE INVESTIGATIONS.

The Department may conduct special investigations of diseases or conditions to identify causes and means of prevention. All records of interviews, reports, studies, and statements obtained by or furnished to the Department or other authorized agency are confidential for the identity of all persons involved. Release of information to the Department as required or permitted by these rules does not subject any party furnishing such information to an action for damages as provided under IDAPA 16.05.01, "Use and Disclosure of Department Records." (3-17-22)

071. -- 079. (RESERVED)

080. DAYCARE FACILITY - REPORTING AND CONTROL MEASURES.

01. Readily Transmissible Diseases. Daycare reportable and restrictable diseases are those diseases that are readily transmissible among children and staff in daycare ~~facilities as listed under Section 050 of these rules.~~ (3-17-22)()

02. Restrictable Disease - Work. A person who is diagnosed to have a daycare restrictable disease must not work in any occupation in which there is direct contact with children in a daycare facility, as long as the disease is in a communicable form. (3-17-22)

03. Restrictable Disease - Attendance. A child who is diagnosed to have a daycare restrictable disease must not attend a daycare facility as long as the disease is in a communicable form. This restriction may be removed by the written certification of a licensed physician, public health nurse or school nurse that the person's disease is no longer communicable. (3-17-22)

04. Prevention of the Transmission of Disease. When satisfactory measures have been taken to prevent the transmission of disease, the affected child or employee may continue to attend or to work in a daycare facility if approval is obtained from the Department or Health District. (3-17-22)

081. -- 084. (RESERVED)

085. FOOD SERVICE FACILITY - REPORTING AND CONTROL MEASURES.

01. Food or Beverage Transmitted Disease in a Communicable Form. ~~Under Section 050 of these rules, a~~ A person who is determined to have ~~one (1) or more of the~~ a diseases or conditions listed ~~in this chapter~~ as restrictable for food establishments must not work as a food employee as long as the disease is in a communicable form. (3-17-22)()

02. Food Employee Health Examination. The Division of Public Health Administrator may require a food employee to submit to an examination to determine the presence of a disease that can be transmitted by means of food when there is reasonable cause to believe the food employee is afflicted with a disease listed ~~in Section 050 of these rules~~ as restrictable for food establishments and that disease is in a communicable form. (3-17-22)()

03. Notification of Disease in a Communicable Form. If the person in charge of an eating or drinking establishment has reason to suspect that any employee has a disease ~~listed in Section 050 of these rules~~ as restrictable for food establishments, and that disease is in a communicable form, the person in charge must immediately notify the Department or Health District and obtain guidance on proper actions needed to protect the public. (3-17-22)()

086. -- 089. (RESERVED)

090. SCHOOL - REPORTING AND CONTROL MEASURES.

01. Restrictable Diseases. School reportable and restrictable diseases are those diseases that are readily transmissible among students and staff in schools as listed ~~under Section 050 of~~ in these rules. (3-17-22)()

02. Restrictions - Work. Any person who is diagnosed to have a school restrictable disease must not work in any occupation that involves direct contact with students in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

03. Restrictions - Attendance. Any person who is diagnosed with or reasonably suspected to have a school restrictable disease must not attend a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

04. Determination Disease Is No Longer Communicable. A licensed physician, public health nurse, school nurse or other person designated by the Department or Health District may determine when a person with a school restrictable disease is no longer communicable. (3-17-22)

05. School Closure. A school administrator must report the closure of any public, parochial, charter, or private school within one (1) working day when, in their opinion, such closing is related to a communicable disease. (3-17-22)

091. HANDLING OF REPORT.

The Department and Health Districts will exchange reported information within one (1) working day. The Department will notify the Idaho Department of Agriculture and any other necessary agency of any identified source or suspected source of any reported case of the following diseases: ()

<u>01. Anthrax:</u>	(<u> </u>)
<u>02. Brucellosis:</u>	(<u> </u>)
<u>03. Leptospirosis:</u>	(<u> </u>)
<u>04. Lyme Disease:</u>	(<u> </u>)
<u>05. Plague:</u>	(<u> </u>)

- 06. Psittacosis;** ()
- 07. O Fever;** ()
- 08. Trichinosis; and** ()
- 09. Tularemia.** ()
- 092. RESTRICTIONS.**
- 01. Restrictions - Daycare Facility.** A person with the following diseases must not attend a daycare facility while fecally incontinent and must not work in any occupation that provides personal care to children while the disease is in a communicable form, unless otherwise specified: ()
- a. Amebiasis and Free-Living Amebae;** ()
- b. Campylobacteriosis;** ()
- c. Cholera;** ()
- d. Conjunctivitis;** ()
- e. Cryptosporidiosis;** ()
- f. Cutaneous Fungal Infections;** ()
- g. Diphtheria;** ()
- h. Escherichia Coli O157:H7 and Other Shiga-Toxin Producing E. Coli (STEC);** ()
- i. Giardiasis;** ()
- j. Haemophilus Influenzae Invasive Disease;** ()
- k. Hepatitis A;** ()
- l. Measles (Rubeola);** ()
- m. Methicillin-Resistant Staphylococcus Aureus (MRSA);** ()
- n. Mumps;** ()
- o. Neisseria Meningitidis Invasive Disease;** ()
- p. Norovirus;** ()
- q. Novel A Influenza Virus;** ()
- r. Pediculosis;** ()
- s. Pertussis;** ()
- t. Plague;** ()
- u. Pneumococcal Invasive Disease In Children Less Than Eighteen Years Of Age;** ()
- v. Poliomyelitis;** ()

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- p.** Shigellosis; ()
- q.** Sore Throat with Fever; ()
- r.** Staphylococcal Infections Other Than MRSA; ()
- s.** Taeniasis; ()
- t.** Tuberculosis; ()
- u.** Uncovered and Open or Draining Skin Lesions with Pus; ()
- v.** Vomiting; ()
- w.** Yersiniosis; and ()
- x.** Viral Hemorrhagic Fever. ()

03. **Restrictions - Health Care Facility.** A symptomatic person with the following diseases must not provide personal care to persons in a health care facility unless otherwise specified: ()

- a.** Amebiasis and Free-Living Amebae; ()
- b.** Campylobacteriosis; ()
- c.** Chlamydia Trachomatis; ()
- d.** Cholera; ()
- e.** Cryptosporidiosis; ()
- f.** Diphtheria; ()
- g.** Escherichia Coli O157:H7 and Other Shiga-Toxin Producing E. Coli (STEC); ()
- h.** Giardiasis; ()
- i.** Hepatitis A; ()
- j.** Measles (Rubeola); ()
- k.** Methicillin-Resistant Staphylococcus Aureus (MRSA); ()
- l.** Mumps; ()
- m.** Neisseria Meningitidis Invasive Disease; ()
- n.** Norovirus; ()
- o.** Novel Influenza A Virus; ()
- p.** Pertussis; ()
- q.** Plague; ()
- r.** Rubella – Including Congenital Rubella Syndrome; ()

- s. Salmonellosis; ()
- t. Shigellosis; ()
- u. Smallpox; ()
- v. Streptococcus Pyogenes (Group A Strep) Infections; ()
- w. Tuberculosis; and ()
- x. Viral Hemorrhagic Fever. ()

04. Restrictions - School. A person with the following diseases must not attend a private, parochial, charter, or public school while fecally incontinent and must not work in any occupation that involves direct contact with students in a private, parochial, charter, or public school while the disease is in a communicable form, unless otherwise specified: ()

- a. Conjunctivitis; ()
- b. Cutaneous Fungal Infections; ()
- c. Diphtheria; ()
- d. Haemophilus Influenzae Invasive Disease; ()
- e. Measles (Rubeola); ()
- f. Methicillin-Resistant Staphylococcus Aureus (MRSA); ()
- g. Mumps; ()
- h. Neisseria Meningitidis Invasive Disease; ()
- i. Norovirus; ()
- j. Novel A Influenza Virus; ()
- k. Pediculosis; ()
- l. Pertussis; ()
- m. Plague; ()
- n. Pneumococcal Invasive Disease In Children Less Than Eighteen Years Of Age; ()
- o. Polio; ()
- p. Rubella – Including Congenital Rubella Syndrome; ()
- q. Scabies; ()
- r. Severe Acute Respiratory Syndrome (SARS), including suspect cases; ()
- s. Shigellosis; ()
- t. Smallpox; ()

~~determine the source of infection. Each reported case of amebiasis must be investigated to determine whether the person with amebiasis is employed as a food employee, provides personal care at a health care or daycare facility, or is a child attending a daycare facility.~~ (3-17-22)

032. Restrictions - Daycare Facility. A person excreting *Entamoeba histolytica* must not attend a daycare facility while fecally incontinent and must not work in any occupation in which they provide personal care to children in a daycare facility, unless an exemption is made by the Department or Health District. (3-17-22)

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or (3-17-22)

b. At least two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Entamoeba histolytica* upon testing by a licensed laboratory. (3-17-22)

043. Restrictions - Food Service Facility. A symptomatic person excreting *Entamoeba histolytica* is restricted from working as a food employee. (3-17-22)

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or (3-17-22)

b. At least two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Entamoeba histolytica* upon testing by a licensed laboratory. (3-17-22)

054. Restrictions - Health Care Facility. A person excreting *Entamoeba histolytica* must not work in any occupation in which they provide personal care to persons confined to a health care facility, unless an exemption is made by the Department or Health District. (3-17-22)

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or (3-17-22)

b. At least two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Entamoeba histolytica* upon testing by a licensed laboratory. (3-17-22)

065. Restrictions - Household Contacts. A member of the household in which there is a case of amebiasis may not work in any occupations in ~~Subsections 110.03 through 110.05 of this rule listed in this Section,~~ unless approved by the Department or Health District. The household member must be asymptomatic and have at least one (1) approved fecal specimen found to be negative for ova and parasites on examination by a licensed laboratory prior to being approved for work. (3-17-22)()

111. -- ~~11959.~~ (RESERVED)

120. ANTHRAX.

01. Reporting Requirements. ~~Each case or suspected case of anthrax in humans must be reported to the Department or Health District immediately, at the time of identification, day or night.~~ (3-17-22)

02. Investigation. ~~Each reported case of anthrax must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of infection.~~ (3-17-22)

03. Handling of Report. ~~The Department and Health District will exchange reported information within one (1) working day of any reported case of anthrax. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of anthrax.~~ (3-17-22)

~~121. — 124.~~ (RESERVED)

125. ARBOVIRAL DISEASES.

01. Reporting Requirements. ~~Each case of suspected or confirmed arboviral disease must be reported to the Department or Health District within three (3) working days of identification. Arboviral diseases include, but are not limited to, those caused by the following viruses: California encephalitis, chikungunya, Colorado tick fever,~~

~~Crimean-Congo hemorrhagic fever, dengue (all subtypes), eastern equine encephalitis, Heartland, Jamestown Canyon, Japanese encephalitis, Keystone, La Crosse, Mayaro, O'nyong-nyong, Powassan, Rift Valley fever, Ross River, St. Louis encephalitis, snowshoe hare, tick-borne encephalitis, Toscana, trivittatus, Venezuelan equine encephalitis, West Nile, western equine encephalitis, yellow fever, and Zika.~~ (3-17-22)

~~**02. Investigation.** Each reported case of arboviral disease must be investigated to confirm the diagnosis, identify the source of infection, and determine if actions need to be taken to prevent additional cases.~~ (3-17-22)

~~**126.—129. (RESERVED)**~~

130. BIOTINIDASE DEFICIENCY.

Each case or suspected case of biotinidase deficiency must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~**131.—139. (RESERVED)**~~

140. BOTULISM.

~~**01. Reporting Requirements.** Each case or suspected case of botulism must be reported to the Department or Health District immediately, at the time of identification, day or night.~~ (3-17-22)

~~**02. Investigation.** Each reported case of botulism must be investigated to confirm the diagnosis, determine if other persons have been exposed to *botulinum* toxins, and identify the source of the disease.~~ (3-17-22)

~~**03. Handling of Report.** The Department and the Health District will exchange reported information within one (1) working day on any reported case of botulism.~~ (3-17-22)

~~**141.—149. (RESERVED)**~~

150. BRUCELLOSIS.

~~**01. Reporting Requirements.** Each case of brucellosis must be reported to the Department or Health District within one (1) working day of identification.~~ (3-17-22)

~~**02. Investigation.** Each reported case of brucellosis must be investigated to confirm the diagnosis and identify the source of the disease.~~ (3-17-22)

~~**03. Handling of Report.** The Department and the Health District will exchange reported information within one (1) working day of any reported case of brucellosis. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of the disease.~~ (3-17-22)

~~**151.—159. (RESERVED)**~~

160. CAMPYLOBACTERIOSIS.

~~**01. Reporting Requirements.** Each case of campylobacteriosis must be reported to Department or Health District within three (3) working days of identification.~~ (3-17-22)

~~**02. Investigation.** Each reported case of campylobacteriosis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection and identify the source of the disease.~~ (3-17-22)

~~**031. Restrictions - Daycare Facility.** A person excreting *Campylobacter* must not provide personal care in a daycare and an fecally incontinent person excreting *Campylobacter* must not attend a daycare facility unless an exemption is obtained from the Department or Health District. Before returning to work or daycare, the person must provide at least two (2) successive approved fecal specimens, collected at least twenty-four (24) hours apart, that fail to show *Campylobacter* upon testing by a licensed laboratory.~~ (3-17-22)

~~04. Restrictions – Food Service Facility. A symptomatic person excreting *Campylobacter* is restricted from working as a food employee. (3-17-22)~~

~~052. Restrictions - Health Care Facility. A person excreting *Campylobacter* must not provide personal care to persons in a health care facility unless an exemption is obtained from the Department or Health District. Before returning to work, the person must provide at least two (2) successive approved fecal specimens, collected at least twenty-four (24) hours apart, that fail to show *Campylobacter* upon testing by a licensed laboratory. (3-17-22)~~

161. -- 169. (RESERVED)

170. CANCER.

~~01. Reporting Requirements. Cancer is to be reported within one hundred and eighty (180) days of its diagnosis or recurrence to the Cancer Data Registry of Idaho (CDRI). (3-17-22)~~

~~02. Handling of Report. All data reported to the CDRI is available for use in aggregate form for epidemiologic analysis of the incidence, prevalence, survival, and risk factors associated with Idaho's cancer experience. Disclosure of confidential information for research projects must comply with the CDRI's confidentiality policies as well as IDAPA 16.05.01, "Use and Disclosure of Department Records." (3-17-22)~~

~~031. Cancers Designated as Reportable. Cancers that are designated reportable to the CDRI include the following as are described in Section 57-1703, Idaho Code. (3-17-22)()~~

~~a. Each in-situ or malignant neoplasm diagnosed by histology, radiology, laboratory testing, clinical observation, autopsy, or suggested by cytology is reportable, excluding basal cell and squamous cell carcinoma of the skin unless occurring on a mucous membrane and excluding in-situ neoplasms of the cervix. (3-17-22)~~

~~b. Benign neoplasms are reportable if occurring in the central nervous system including the brain, meninges, pineal gland, or pituitary gland. (3-17-22)~~

~~ea. The use of the words "apparently," "appears to," "comparable with," "compatible with," "consistent with," "favor," "malignant appearing," "most likely," "presumed," "probable," "suspected," "suspicious," or "typical" is sufficient to make a case reportable. (3-17-22)~~

~~eb. The use of the words "questionable," "possible," "suggests," "equivocal," "approaching," "rule out," "potentially malignant," or "worrisome," is not sufficient to make a case reportable. (3-17-22)~~

~~042. Report Content. Each reported case must include the patient's name, demographic information, date of diagnosis, primary site, metastatic sites, histology, stage of disease, initial treatments, subsequent treatment, and survival time. Reporting of cases must adhere to cancer reporting standards as provided in "Standards for Cancer Registries, Vol. II." as incorporated by reference in Section 004 of these rules. (3-17-22)()~~

~~053. Reported By Whom. Every private, federal, or military hospital, out-patient surgery center, radiation treatment center, pathology laboratory, or physician providing a diagnosis or treatment related to a reportable cancer is responsible for reporting or furnishing cancer-related data, including annual follow-up, to CDRI. (3-17-22)~~

171. -- 179. (RESERVED)

180. CHANCROID.

~~01. Reporting Requirements. Each case of chaneroid must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation and Notification of Contacts. Each reported case of chaneroid must be investigated to determine the source and extent of contact follow-up that is required. Each person diagnosed with chaneroid is~~

~~required to inform all sexual contacts that they have been exposed to a sexually transmitted infection, or to provide specific information to health officials in order to locate these contacts. The contacts must be notified of the disease in order to be examined and treated according to Section 39-605, Idaho Code.~~ (3-17-22)

~~181.—189. (RESERVED)~~

~~190. CHLAMYDIA TRACHOMATIS.~~

~~01. Reporting Requirements. Each case of *Chlamydia trachomatis* infection must be reported to the Department or Health District within three (3) working days of identification.~~ (3-17-22)

~~02. Investigation. Each reported case of *Chlamydia trachomatis* pelvic inflammatory disease may be investigated to determine the extent of contact follow-up that is required.~~ (3-17-22)

~~03. Prophylaxis of Newborns. Prophylaxis against *Chlamydia trachomatis* ophthalmia neonatorum is required in IDAPA 16.02.12, “Newborn Screening.”~~ (3-17-22)

~~04. Restrictions — Health Care Facility. A person with *Chlamydia trachomatis* ophthalmia neonatorum in a health care facility must be managed under the “Guideline for Isolation Precautions in Hospitals” as incorporated by reference in Section 004 of these rules.~~ (3-17-22)

~~191.—199. (RESERVED)~~

~~200. CHOLERA.~~

~~01. Reporting Requirements. Each case or suspected case of cholera must be reported to the Department or Health District within one (1) working day.~~ (3-17-22)

~~02. Investigation. Each reported case of cholera must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify contacts, carriers, and the source of the infection.~~ (3-17-22)

~~03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of cholera.~~ (3-17-22)

~~04. Restrictions — Daycare Facility. A person excreting *Vibrio cholerae* must not attend a daycare facility while fecally incontinent and must not work in any occupation that provides personal care to children in a daycare facility while the disease is in a communicable form, unless an exemption is obtained from the Department or Health District.~~ (3-17-22)

~~05. Restrictions — Food Service Facility. A symptomatic person excreting *Vibrio cholerae* must be managed under IDAPA 16.02.19, “Idaho Food Code.”~~ (3-17-22)

~~06. Restrictions — Health Care Facility. A person excreting *Vibrio cholerae* must not work in any occupation that provides personal care to persons confined in a health care or residential facility while in a communicable form, unless an exemption is obtained from the Department or Health District. A person in a health care facility who has cholera must be managed under the “Guideline for Isolation Precautions in Hospitals,” as incorporated in Section 004 of these rules.~~ (3-17-22)

~~07. Restrictions — Household Contacts. A member of the household in which there is a case of cholera may not work in any occupations listed specified in Subsections 200.04 through 200.06 of this rule, unless approved by the Department or Health District. The household member must be asymptomatic and provide at least one (1) approved fecal specimen found to be negative on a culture by a licensed laboratory prior to being approved for work.~~ (3-17-22)()

~~201. -- 209. (RESERVED)~~

~~210. CONGENITAL HYPOTHYROIDISM.~~

~~Each case or suspected case of congenital hypothyroidism must be reported to the Department or Health District within one (1) working day of identification.~~ (3-17-22)

~~211.~~ 219. (RESERVED)

220. CRYPTOSPORIDIOSIS.

~~01. Reporting Requirements.~~ Each case of cryptosporidiosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case must be investigated to identify clusters or outbreaks of the infection, and identify the source of the infection. (3-17-22)

~~03.~~ 031. **Restrictions - Daycare Facility.** A fecally incontinent person excreting *Cryptosporidium* must not attend a daycare facility. A person excreting *Cryptosporidium* must not provide personal care in a daycare facility, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: (3-17-22)

a. At least two (2) successive fecal specimens collected at least twenty-four (24) hours apart fail to show *Cryptosporidium* upon testing by a licensed laboratory; or (3-17-22)

b. Diarrhea has ceased for twenty-four (24) hours. (3-17-22)

~~04. Restrictions — Food Service Facility.~~ A symptomatic person excreting *Cryptosporidium* is restricted from working as a food employee. (3-17-22)

~~05.~~ 052. **Restrictions - Health Care Facility.** A person excreting *Cryptosporidium* must not provide personal care in a custodial institution, or health care facility while fecally incontinent, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: (3-17-22)

a. At least two (2) successive fecal specimens collected at least twenty-four (24) hours apart fail to show *Cryptosporidium* upon testing by a licensed laboratory; or (3-17-22)

b. Diarrhea has ceased for twenty-four (24) hours. (3-17-22)

221. -- 229. (RESERVED)

230. DIPHTHERIA.

~~01. Reporting Requirements.~~ Each case or suspected case of diphtheria must be reported to the Department or Health District immediately, at the time of identification, day or night. (3-17-22)

~~02. Investigation and Response.~~ Each reported case of diphtheria must be investigated to determine if the illness is caused by a toxigenic strain of *Corynebacterium diphtheriae*, identify clusters or outbreaks of the infection, and identify contacts, carriers, and the source of the infection. Contacts of a person with toxigenic diphtheria will be offered immunization against diphtheria. (3-17-22)

~~03. Handling of Report.~~ The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case of diphtheria. (3-17-22)

~~04. Restrictions — Daycare Facility.~~ A person diagnosed with diphtheria must be managed under Section 080 of these rules. (3-17-22)

~~05.~~ 051. **Restrictions - Health Care Facility.** (3-17-22)

a. A person with oropharyngeal toxigenic diphtheria in a health care facility must be managed under the “Guideline for Isolation Precautions in Hospitals,” ~~as incorporated in Section 004 of these rules.~~ The Department

or Health District may withdraw this isolation requirement after two (2) cultures of the nose and two (2) cultures from the throat, taken at least twenty-four (24) hours apart and at least twenty-four (24) hours after the completion of antibiotic therapy, fail to show toxigenic *Corynebacterium diphtheriae* upon testing by a licensed laboratory.

(3-17-22)()

b. A person with cutaneous toxigenic diphtheria must be placed under contact precautions. The Department or Health District may withdraw these precautions after two (2) cultures from the wound fail to show toxigenic *Corynebacterium diphtheriae* upon testing by a licensed laboratory.

(3-17-22)

062. Restrictions - Contacts. Contacts of a person with toxigenic diphtheria are restricted from working as food employees, working in health care facilities, or from attending or working in daycare facilities or schools until they are determined not to be carriers by means of a nasopharyngeal culture or culture of other site suspected to be infected. These restrictions may be withdrawn by the Department or Health District.

(3-17-22)

~~231. --234.~~ (RESERVED)

~~235.~~ ECHINOCOCCOSIS.

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

(3-17-22)

~~02. Investigation.~~ Each reported case of echinococcosis must be investigated to confirm the diagnosis and to identify possible sources of the infection.

(3-17-22)

~~236. --239.~~ (RESERVED)

~~240.~~ ENCEPHALITIS, VIRAL OR ASEPTIC.

~~01. Reporting Requirements.~~ Each case of viral or aseptic encephalitis, including meningoencephalitis, must be reported to the Department or Health District within three (3) working days of identification.

(3-17-22)

~~02. Investigation.~~ Each reported case of viral or aseptic encephalitis meningoencephalitis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection.

(3-17-22)

~~241. -- 249.~~ (RESERVED)

250. ESCHERICHIA COLI O157:H7 AND OTHER SHIGA-TOXIN PRODUCING E. COLI (STEC).

~~01. Reporting Requirements.~~ Each case or suspected case of *Escherichia coli* O157:H7 or other Shiga-toxin producing *E. coli* (STEC) must be reported to the Department or Health District within one (1) working day of identification.

(3-17-22)

~~02. Investigation.~~ Each reported case must be investigated to determine if the person is employed as a food employee, provides personal care at a health care or daycare facility, or is a child attending a daycare facility. The investigation identifies clusters or outbreaks of the infection, and the most likely source of the infection.

(3-17-22)

~~03. Handling of Report.~~ The Department and the Health District will exchange reported information within one (1) working day on any reported case of *E. coli* O157:H7 or other Shiga-toxin producing *E. coli* (STEC).

(3-17-22)

041. Restrictions - Daycare Facility. A person who is excreting *E. coli* O157:H7 or other STEC must not attend daycare facilities while fecally incontinent or provide personal care to children in a daycare facility while the disease is present in a communicable form without the approval of the Department or Health District. Before returning to work or attendance at a daycare, the person must provide two (2) successive approved fecal specimens

collected at least twenty-four (24) hours apart, that fail to show *E. coli* O157:H7 or other STEC. (3-17-22)

~~05. **Restrictions – Food Service Facility.** A person diagnosed with *E. coli* O157:H7 or other STEC must be managed under IDAPA 16.02.19, “Idaho Food Code.” (3-17-22)~~

~~062. **Restrictions - Health Care Facility.** A person who is excreting *E. coli* O157:H7 or other STEC must not provide personal care to persons in a health care facility while the disease is present in a communicable form without the approval of the Department or Health District. Before returning to work, the person must provide two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart, that fail to show *E. coli* O157:H7 or other STEC. (3-17-22)~~

~~251. --259. (RESERVED)~~

~~260. **EXTRAORDINARY OCCURRENCE OF ILLNESS, INCLUDING CLUSTERS.**~~

~~01. **Reporting Requirements.** Cases, suspected cases, and clusters of extraordinary or unusual illness must be reported to the Department or Health District within one (1) working day by the diagnosing person. (3-17-22)~~

~~a. Unusual outbreaks include illnesses that may be a significant risk to the public, may involve a large number of persons, or are a newly described entity. (3-17-22)~~

~~b. Even in the absence of a defined etiologic agent or toxic substance, clusters of unexplained acute illness and early-stage disease symptoms must be reported to the Department or Health District within one (1) working day and investigated. (3-17-22)~~

~~02. **Investigation.** Each reported case of extraordinary occurrence of illness, including clusters, must be investigated to confirm the diagnosis, determine the extent of the cluster or outbreak, identify the source of infection or exposure, and determine whether there is a risk to the public warranting intervention by a public health agency. Evaluation and control measures will be undertaken in consultation with the Department and other appropriate agencies. The Department may elect to investigate by conducting special studies as outlined in Section 070 of these rules. (3-17-22)~~

~~03. **Handling of Report.** The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case. (3-17-22)~~

~~261. --269. (RESERVED)~~

~~270. **FOOD POISONING, FOODBORNE ILLNESS, AND WATERBORNE ILLNESS.**~~

~~01. **Reporting Requirements.** Each case, suspected case, or outbreak of food poisoning, foodborne illness, or waterborne illness must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

~~02. **Investigation.** Each reported case or outbreak of food poisoning, foodborne illness, or waterborne illness must be investigated to confirm the diagnosis, determine the extent of transmission, identify the source, and determine if actions need to be taken to prevent additional cases. (3-17-22)~~

~~03. **Handling of Report.** The Department and the Health District will exchange reported information within one (1) working day of any reported case or suspected case. (3-17-22)~~

~~271. --279. (RESERVED)~~

~~280. **GALACTOSEMIA.**~~

~~Each case or suspected case of galactosemia must be reported to the Department or Health District within one (1) working day after diagnosis. (3-17-22)~~

~~281.~~ 289. (RESERVED)

290. GIARDIASIS.

~~01. Reporting Requirements.~~ Each case of giardiasis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of giardiasis must be investigated to determine if the person is employed as a food employee, provides personal care at a health care or daycare facility, or is a child attending a daycare facility. The investigation identifies clusters or outbreaks of the infection, and the most likely source of the infection. (3-17-22)

~~03.~~ **Restrictions - Daycare Facility.** A person with diarrhea who is excreting *Giardia lamblia* must not attend daycare while fecally incontinent or provide personal care to children in a daycare facility while the disease is present in a communicable form or until therapy is completed. An asymptomatic person may provide these services or attend daycare with specific approval of the Department or Health District. (3-17-22)

~~04. Restrictions — Food Service Facility.~~ A symptomatic person who is excreting *Giardia lamblia* must be managed under IDAPA 16.02.19, “Idaho Food Code.” (3-17-22)

~~05.~~ **Restrictions - Health Care Facility.** A person with diarrhea who is excreting *Giardia lamblia* must not provide personal care to persons in a health care facility while the disease is present in a communicable form or until therapy is completed. An asymptomatic person may provide these services with specific approval of the Department or Health District. (3-17-22)

291. --~~299.~~ (RESERVED)

~~300. HAEMOPHILUS INFLUENZAE INVASIVE DISEASE.~~

~~01. Reporting Requirements.~~ Each case or suspected case of *Haemophilus influenzae* invasive disease, including, but not limited to, meningitis, septicemia, bacteremia, epiglottitis, pneumonia, osteomyelitis and cellulitis, must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of *Haemophilus influenzae* invasive disease must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify contacts, and determine the need for antimicrobial prophylaxis of close contacts. (3-17-22)

~~03. Handling of Report.~~ The Department and the Health District will exchange reported information within one (1) working day on any reported case of *Haemophilus influenzae* invasive disease. (3-17-22)

~~04. Restrictions — Daycare Facility.~~ A person who is diagnosed with invasive disease caused by *Haemophilus influenzae* must not work in an occupation providing personal care to children, or attend a daycare facility as long as the disease is in a communicable form. (3-17-22)

~~05. Restrictions — School.~~ A person who is diagnosed with invasive disease caused by *Haemophilus influenzae* must not work in any occupation where there is direct contact with students or attend a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

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

340. HANTAVIRUS PULMONARY SYNDROME.

~~01. Reporting Requirements.~~ Each case or suspected case of hantavirus pulmonary syndrome must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of hantavirus pulmonary syndrome must be investigated to

confirm the diagnosis, determine environmental risk factors leading to the infection, and determine any other at-risk individuals. (3-17-22)

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day by telephone on any reported case or suspected case of hantavirus pulmonary syndrome. (3-17-22)

311.—319. (RESERVED)

320. HEMOLYTIC-UREMIC SYNDROME (HUS):

01. Reporting Requirements. Each case of hemolytic-uremic syndrome (HUS) or thrombotic thrombocytopenic purpura-HUS (TTP-HUS) must be reported to the Department or Health District within one (1) working day. (3-17-22)

02. Investigation. Each case of HUS or TTP-HUS must be investigated to confirm the diagnosis, determine the etiologic agent including *E. coli* O157:H7, non-O157 Shiga toxin producing *E. coli*, or other enteric pathogens, and determine the source of infection. (3-17-22)

321.—329. (RESERVED)

330. HEPATITIS A.

01. Reporting Requirements. Each case or suspected case of hepatitis A must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

02. Investigation. Each reported case of hepatitis A must be investigated to confirm the diagnosis, identify contacts, determine the need for immune serum globulin (gamma globulin) or vaccine, and identify possible sources of the infection. (3-17-22)

03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis A when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services. (3-17-22)

04. Restrictions—Daycare Facility. A child who has hepatitis A must not attend a daycare facility until the disease is no longer communicable as determined by a licensed physician, or unless an exemption is made by the Department or Health District. (3-17-22)

a. A person with hepatitis A must not work in any occupation in which personal care is provided to children in a daycare facility while the disease is in a communicable form. (3-17-22)

b. The Department or Health District may withdraw this restriction when the illness is considered to no longer be in a communicable form. (3-17-22)

05. Exclusion—Food Service Facility. (3-17-22)

a. A food employee with hepatitis A must be managed under IDAPA 16.02.19, "Idaho Food Code." (3-17-22)

b. A specific test for recent hepatitis A infection (IgM antiHAV) must be performed by a licensed laboratory on all food employees suspected of having hepatitis A. (3-17-22)

06. Restrictions—Health Care Facility. A person with hepatitis A in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. (3-17-22)

a. A person with hepatitis A must not work in any occupation in which personal care is provided to

~~persons who are in a health care facility or living in a residential care facility while the disease is in a communicable form.~~ (3-17-22)

~~b. The Department or Health District may withdraw this restriction when the illness is considered to no longer be in a communicable form.~~ (3-17-22)

071. Restrictions - Household Contacts. Any unvaccinated household member where there is a case of hepatitis A must not work in any of the occupations listed in ~~Subsections 330.04 through 330.06 of this rule~~ this Section, unless an exemption is obtained from the Department or Health District. (3-17-22)()

331. -- 339. (RESERVED)

340. HEPATITIS B.

~~**01. Reporting Requirements.** Each case or suspected case of hepatitis B must be reported to the Department or Health District within one (1) working day of identification.~~ (3-17-22)

021. Investigation. Each reported case of hepatitis B must be investigated to confirm the diagnosis, identify contacts and carriers, determine the need for prophylaxis with immune globulins, determine the need for hepatitis B vaccine, determine the exposure of any pregnant women, and identify possible sources of the infection. (3-17-22)

~~**03. Testing Without an Informed Consent.** A physician may order blood tests for hepatitis B when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services.~~ (3-17-22)

042. Carrier Status. The carrier status of a person diagnosed with hepatitis B will be determined six (6) months after the initial diagnosis is established. (3-17-22)

~~a. The carrier status will be determined by the presence of hepatitis B surface antigen (HBsAg) in blood obtained at least six (6) months after the initial diagnosis of hepatitis B.~~ (3-17-22)

~~b. The test for hepatitis B surface antigen (HBsAg) must be performed by a licensed laboratory.~~ (3-17-22)

ea. A person who is a carrier of hepatitis B must be reported to the Department or Health District by the physician at the time of determination for inclusion in the hepatitis B carrier registry. (3-17-22)

341. --349. (RESERVED)

350. HEPATITIS C.

~~**01. Reporting Requirements.** Each case of hepatitis C must be reported to the Department or Health District within three (3) working days of identification.~~ (3-17-22)

~~**02. Investigation.** Each reported case of hepatitis C must be investigated to confirm the diagnosis and identify possible sources of the infection. Hepatitis C may be confirmed by presence of hepatitis C antibody or antigen.~~ (3-17-22)

~~**03. Testing Without an Informed Consent.** A physician may order blood tests for hepatitis C when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services.~~ (3-17-22)

~~**351. -- 359. (RESERVED)**~~

360. HUMAN IMMUNODEFICIENCY VIRUS (HIV).

01. Reporting Requirements. Each case of HIV infection, including clinical diagnosis, positive HIV laboratory tests for HIV antibody, HIV antigen (protein or nucleic acid), human immunodeficiency virus isolations, or other tests of infectiousness that indicate HIV infection, must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)()

~~**02. Investigation.** Each reported case of HIV infection must be investigated to obtain specific clinical information, identify possible sources, risk factors, and contacts. Other manifestations of HIV infection as defined by the Centers for Disease Control and Prevention may be investigated.~~ (3-17-22)

~~**03. Testing Without an Informed Consent.** A physician may order blood tests for HIV when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services.~~ (3-17-22)

361. -- 369. (RESERVED)

370. HUMAN T-LYMPHOTROPIC VIRUS.

~~**01. Reporting Requirements.** Each case of HTLV infection must be reported to the Department or Health District within three (3) working days of identification.~~ (3-17-22)

~~**02. Investigation.** Each reported case of HTLV infection must be investigated to determine the source of infection and evaluate risk factors.~~ (3-17-22)

~~**371. — 379. (RESERVED)**~~

380. LEAD POISONING.

01. Reporting Requirements. Each case of lead poisoning must be reported to the Department or Health District within three (3) working days of the identification of the case when determined by symptoms or a blood level of:

a. Ten (10) micrograms or more per deciliter (10 ug/dL) of blood in adults eighteen (18) years and older; or (3-17-22)

b. Five (5) Three and a half (3.5) micrograms or more per deciliter (3.5 ug/dL) of blood in children under eighteen (18) years of age. (3-17-22)

~~**02. Investigation.** Each reported case of lead poisoning or excess lead exposure may be investigated to confirm blood lead levels, determine the source, and whether actions need to be taken to prevent additional cases.~~ (3-17-22)

381. -- 389. (RESERVED)

390. LEGIONELLOSIS.

~~**01. Reporting Requirements.** Each case of legionellosis must be reported to the Department or Health District within three (3) working days of identification.~~ (3-17-22)

~~**02. Investigation.** Each reported case of legionellosis must be investigated to confirm the diagnosis and identify possible sources of the infection. When two (2) or more cases occur within thirty (30) days of each other, an investigation must be conducted to identify a common environmental source and identify ways to prevent further infections.~~ (3-17-22)

~~**391. — 399. (RESERVED)**~~

400. LEPROSY (HANSEN'S DISEASE).

~~01. Reporting Requirements.~~ Each case of leprosy must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of leprosy must be investigated to confirm the diagnosis and to identify household or other close contacts. (3-17-22)

~~03. Restrictions—Examination of Contacts.~~ All household members or close contacts of a new case must be examined should be recommended to receive evaluation by a licensed physician for signs of leprosy. Household members and close contacts and persons in remission must be registered with the Department and undergo periodic medical examinations every six (6) to twelve (12) months for five (5) years and consideration of chemoprophylaxis. (3-17-22)()

~~401. --409. (RESERVED)~~

410. LEPTOSPIROSIS.

~~01. Reporting Requirements.~~ Each case of leptospirosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of leptospirosis must be investigated to confirm the diagnosis and to identify possible sources of the infection. (3-17-22)

~~03. Handling of Report.~~ Any identified or suspected source of infection reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. (3-17-22)

~~411. —419. (RESERVED)~~

420. LISTERIOSIS.

~~01. Reporting Requirements.~~ Each case of listeriosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of listeriosis must be investigated to confirm the diagnosis and to identify possible sources of the infection and extent of the outbreak. (3-17-22)

~~421. —429. (RESERVED)~~

430. LYME DISEASE.

~~01. Reporting Requirements.~~ Each case of Lyme disease must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of Lyme disease must be investigated to confirm the diagnosis and to identify possible sources of the infection. (3-17-22)

~~03. Handling of Report.~~ Any identified or suspected source of infection reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. (3-17-22)

~~431. —439. (RESERVED)~~

440. MALARIA.

~~01. Reporting Requirements.~~ Each case of malaria must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of malaria must be investigated to determine the type and the source of the infection. If transmission may have occurred in Idaho, an entomologic investigation will be performed

by the Department or Health District to determine the extent of mosquito activity, and to institute control measures if endemic transmission is determined. (3-17-22)

~~03. Testing Without an Informed Consent.~~ A physician may order blood tests for malaria when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. (3-17-22)

~~441. — 449. (RESERVED)~~

450. MAPLE SYRUP URINE DISEASE.

Each case or suspected case of maple syrup urine disease must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~451. — 459. (RESERVED)~~

460. MEASLES (RUBEOLA).

~~01. Reporting Requirements.~~ Each case or suspected case of measles must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of measles must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify the source of the infection, and to identify susceptible contacts. (3-17-22)

~~03. Handling of Report.~~ The Department and the Health District will exchange reported information within one (1) working day on any reported case of measles. (3-17-22)

~~04.1. Restrictions - Daycare Facility and School.~~ (3-17-22)

~~a.~~ A child diagnosed with measles must not attend a daycare facility or school as long as the disease is in a communicable form. (3-17-22)

~~b.~~ *In the event of a case of measles in a daycare or school, susceptible children must be excluded until adequate immunization is obtained, or the threat of further spread of the disease is contained, as provided in Sections 33-512(7) and 39-1118, Idaho Code.* (3-17-22)

~~c.~~ A person who is diagnosed as having measles must not work in any occupation in which there is direct contact with children, as long as the disease is in a communicable form. (3-17-22)

~~05. Restrictions — Health Care Facility.~~ A person diagnosed with measles in a health care facility must be managed under the “Guideline for Isolation Precautions in Hospitals,” as incorporated by reference in Section 004 of these rules. (3-17-22)

~~461. -- 469. (RESERVED)~~

470. MENINGITIS, VIRAL OR ASEPTIC.

~~01. Reporting Requirements.~~ Each case of viral or aseptic meningitis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of viral or aseptic meningitis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection. (3-17-22)

~~471. — 474. (RESERVED)~~

475. METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA).

01. Reporting Requirements. Each case or suspected case of invasive methicillin-resistant *Staphylococcus aureus* (MRSA), defined as MRSA isolated from a normally sterile site, must be reported to the Department or Health District within three (3) working days of identification by the laboratory director. (3-17-22)

~~**02. Investigation.** Any case of MRSA may be investigated to determine source and recommend measures to prevent spread. (3-17-22)~~

~~**03.2. Restrictions - Daycare Facility.** A person who is diagnosed with MRSA infection must not work in an occupation providing personal care to children, or attend a daycare facility, if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and (3-17-22)~~

~~**a.** The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or (3-17-22)~~

~~**b.** The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage. (3-17-22)~~

~~**04. Restrictions - Food Service Facility.** A food employee diagnosed with MRSA infection must be managed under IDAPA 16.02.19, "Idaho Food Code." (3-17-22)~~

~~**05.3. Restrictions - Health Care Facility.** A person who is diagnosed with MRSA infection must not provide personal care to persons in a health care facility if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and (3-17-22)~~

~~**a.** The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or (3-17-22)~~

~~**b.** The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage. (3-17-22)~~

~~**06.4. Restrictions - School.** A person who is diagnosed with MRSA infection must not work in an occupation where there is direct contact with students or attend a private, parochial, charter, or public school, if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and (3-17-22)~~

~~**a.** The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or (3-17-22)~~

~~**b.** The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage. (3-17-22)~~

~~476. --479. (RESERVED)~~

~~480. MUMPS.~~

~~**01. Reporting Requirements.** Each case of mumps must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~**02. Investigation.** Each reported case of mumps must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify the source of the infection, and to identify susceptible contacts. (3-17-22)~~

~~**03. Restrictions.** A person with mumps must be restricted from daycare, school, or work for five (5) days after the onset of parotid swelling. (3-17-22)~~

~~481. --489. (RESERVED)~~

~~490. MYOCARDITIS, VIRAL.~~

01. Reporting Requirements. Each case of viral myocarditis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

02. Investigation. Each reported case of viral myocarditis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection. (3-17-22)

491.—499. (RESERVED)

500. NEISSERIA GONORRHOEAE.

01. Reporting Requirements. Each case of *Neisseria gonorrhoeae* infection must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

02. Investigation. A person diagnosed with urethral, cervical, oropharyngeal, or rectal gonorrhea is required to inform all sexual contacts or provide sufficient information to health officials in order to locate these contacts. The contacts must be advised of their exposure to a sexually transmitted infection and informed they should seek examination and treatment. (3-17-22)

03. Prophylaxis of Newborns. Prophylaxis against gonococcal ophthalmia neonatorum is described in IDAPA 16.02.12, "Newborn Screening." (3-17-22)

04. Isolation—Health Care Facility. A person with gonococcal ophthalmia neonatorum in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. (3-17-22)

501.—509. (RESERVED)

510. NEISSERIA MENINGITIDIS INVASIVE DISEASE.

01. Reporting Requirements. Each case or suspected case of *Neisseria meningitidis* invasive disease, including meningitis and septicemia, must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

02. Investigation. Each reported case of *Neisseria meningitidis* invasive disease must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify contacts, and determine the need for antimicrobial prophylaxis or immunization of close contacts. (3-17-22)

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of *Neisseria meningitidis* invasive disease. (3-17-22)

04. Restrictions—Daycare Facility. A person who is diagnosed with a disease caused by *Neisseria meningitidis* must not provide personal care to children, or attend a daycare facility, as long as the disease is present in a communicable form. (3-17-22)

05. Restrictions—Health Care Facility. A person with *Neisseria meningitidis* in a health care facility or residential care facility must be placed under respiratory isolation until twenty-four (24) hours after initiation of effective therapy. (3-17-22)

06. Restrictions—School. A person who is diagnosed with a disease caused by *Neisseria meningitidis* must not work in any occupation that involves direct contact with students, or attend a private, parochial, charter, or public school as long as the disease is present in a communicable form. (3-17-22)

511.—519. (RESERVED)

520. NOROVIRUS.

~~01. Reporting Requirements.~~ Each case or suspected case of norovirus must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of norovirus must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection. (3-17-22)

~~03. Restrictions—Daycare Facility.~~ A person excreting norovirus must not attend or provide personal care in a daycare while symptomatic, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic for at least twenty-four (24) hours. (3-17-22)

~~04. Exclusions—Food Service Facility.~~ A person suspected of infection with, or diagnosed with, norovirus is excluded from working as a food employee while symptomatic, unless an exemption is made by the Department or Health District. This exclusion will be withdrawn once the person is asymptomatic for at least twenty-four (24) hours. (3-17-22)

~~05. Restrictions—Health Care Facility.~~ A person excreting norovirus must not provide personal care in a health care facility, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic for at least twenty-four (24) hours. (3-17-22)

~~06. Restrictions—School.~~ A person excreting norovirus must not attend or work in a private, parochial, charter, or public school while symptomatic, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic for at least twenty-four (24) hours. (3-17-22)

~~521. (RESERVED)~~

~~522. NOVEL INFLUENZA A VIRUS:~~

~~01. Reporting Requirements.~~ (3-17-22)

~~a.~~ Each detection of a novel influenza A virus must be reported to the Department or Health District within one (1) working day of identification by the laboratory director. (3-17-22)

~~b.~~ Each probable or confirmed case of a novel influenza A infection resulting in hospitalization must be reported to the Department or Health District within one (1) working day of the event. (3-17-22)

~~02. Investigation.~~ Any case of a novel influenza A infection may be investigated to determine severity and recommend measures to prevent spread. (3-17-22)

~~03. Restrictions.~~ A person diagnosed with novel influenza A virus infection must be restricted from daycare, school, or work for twenty-four (24) hours after the fever is resolved. Fever must be absent without the aid of fever-reducing medicine. (3-17-22)

~~523.—529. (RESERVED)~~

~~530. PERTUSSIS:~~

~~01. Reporting Requirements.~~ Each case or suspected case of pertussis must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of pertussis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify susceptible contacts, and identify the source of the infection. (3-17-22)

~~03. Restrictions—Daycare Facility.~~ A person who is diagnosed with pertussis must not work in any occupation in which there is direct contact with children, or attend a daycare facility, as long as the disease is in a communicable form. (3-17-22)

~~04. Restrictions—Health Care Facility.~~ A person who is diagnosed with pertussis must not work in any occupation in which there is direct contact with other persons in a health care facility as long as the disease is in a communicable form. (3-17-22)

~~05. Restrictions—School.~~ A person diagnosed with pertussis must not attend or work in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

~~531.—539. (RESERVED)~~

~~540. PHENYLKETONURIA.~~

Each case or suspected case of phenylketonuria must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~541.—549. (RESERVED)~~

550. PLAGUE.

~~01. Reporting Requirements.~~ Each case or suspected case of plague must be reported to the Department or Health District immediately, at the time of identification, day or night. (3-17-22)

~~02. Investigation.~~ Each reported case of plague must be investigated to confirm the diagnosis, determine the source, identify clusters or outbreaks of the infection, and whether there has been person-to-person transmission. (3-17-22)

~~03. Handling of Report.~~ Each case of plague reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. (3-17-22)

~~04. Restrictions—Daycare Facility.~~ A person who is diagnosed with pneumonic plague must not work in any occupation in which there is direct contact with children, or attend a daycare facility, as long as the disease is in a communicable form. (3-17-22)

~~05. Restrictions—Health Care Facility.~~ (3-17-22)

~~a.~~ A person with or suspected of having pneumonic plague in a health care facility must be managed under the “Guideline for Isolation Precautions in Hospitals,” as incorporated in Section 004 of these rules. (3-17-22)

~~b.~~ A person with or suspected of having bubonic plague in health care facility must be managed under the “Guideline for Isolation Precautions in Hospitals,” as incorporated in Section 004 of these rules. (3-17-22)

~~06. Restrictions—School.~~ A person diagnosed with pneumonic plague must not attend or work in any occupation in which there is direct contact with children, in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

~~07. Prophylaxis of Contacts.~~ Household members and face-to-face contacts of a person with pneumonic plague must be ~~placed on~~ offered chemoprophylaxis and placed under surveillance for seven (7) days. A person who refuses chemoprophylaxis must be maintained under ~~droplet precautions with careful~~ surveillance for seven (7) days. (3-17-22)()

~~551.—559. (RESERVED)~~

~~560. PNEUMOCOCCAL INVASIVE DISEASE IN CHILDREN LESS THAN EIGHTEEN YEARS OF AGE.~~

~~01. Reporting Requirements.~~ Each case of pneumococcal invasive disease in children under eighteen (18) years of age including, but not limited to, meningitis, septicemia, and bacteremia, must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of pneumococcal invasive disease in children must be investigated to confirm the diagnosis and determine relevant vaccine history. (3-17-22)

~~03. Restrictions—Daycare Facility.~~ A person who is diagnosed with pneumococcal invasive disease must not attend daycare or work in any occupation in which there is direct contact with children in a daycare facility as long as the disease is in a communicable form. (3-17-22)

~~04. Restrictions—School.~~ A person diagnosed with pneumococcal invasive disease must not attend or work in any occupation in which there is direct contact with children in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

~~561. -- 569.~~ (RESERVED)

570. PNEUMOCYSTIS PNEUMONIA (PCP).

~~01. Reporting Requirements.~~ Each case of *Pneumocystis pneumonia* (PCP) must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of *Pneumocystis pneumonia* (PCP) must be investigated to confirm the diagnosis, and to determine the underlying cause of any immune deficiency that may have whether HIV contributed to the disease. ~~When the underlying cause is an HIV infection, it must be reported as described in Section 360 of these rules.~~ (3-17-22)()

~~571. -- 579.~~ (RESERVED)

580. POLIOMYELITIS.

~~01. Reporting Requirements.~~ Each case or suspected case of poliomyelitis infection must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of poliomyelitis infection must be investigated to confirm the diagnosis, to determine whether the case is polio vaccine associated or wild virus associated, identify clusters or outbreaks of the infection, whether there has been person-to-person transmission, and to identify susceptible contacts, carriers, and source of the infection. (3-17-22)

~~03. Immunization of Personal Contacts.~~ The immunization status of personal contacts is should be determined and susceptible contacts are offered recommended to receive immunization. (3-17-22)()

~~04. Restrictions—Daycare Facility.~~ A person who is diagnosed with poliomyelitis infection must not work in any occupation in which there is direct contact with children, or attend a daycare facility, as long as the disease is in a communicable form. (3-17-22)

~~05. Restrictions—School.~~ A person diagnosed with poliomyelitis infection must not attend or work in any occupation in which there is direct contact with children, in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

~~581. -- 589.~~ (RESERVED)

590. PSITTACOSIS.

~~01. Reporting Requirements.~~ Each case of psittacosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify possible sources of the infection. (3-17-22)

~~03. Handling of Report.~~ Any identified sources or suspected sources of infection must be reported to

the Department which will notify the Idaho Department of Agriculture if birds or other animals are involved.
(3-17-22)

~~591.—599. (RESERVED)~~

~~600. Q-FEVER.~~

~~01. Reporting Requirements.~~ Each case or suspected case of Q fever must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of Q fever must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection. (3-17-22)

~~03. Handling of Report.~~ Any identified or suspected sources of infection must be reported to the Department which will notify the Idaho Department of Agriculture if animals are involved. (3-17-22)

~~601.—609. (RESERVED)~~

610. RABIES - HUMAN, ANIMAL, AND POST-EXPOSURE PROPHYLAXIS (RPEP).

01. Reporting Requirements. (3-17-22)

~~a.~~ Each case or suspected case of rabies in humans must be reported to the Department or Health District immediately, at the time of identification, day or night. (3-17-22)

~~ba.~~ Each case of rabies in animals or rabies post-exposure prophylaxis series initiation in a human must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)()

~~e.~~ Each instance of rabies post-exposure prophylaxis (rPEP) series initiation must be reported to the Department or Health District within one (1) working day. (3-17-22)

~~02. Investigation.~~ (3-17-22)

~~a.~~ Each reported case or suspected case of rabies in humans must be investigated to confirm the diagnosis, identify the source and other persons or animals that may have been exposed to the source, and identify persons who may need to undergo rPEP. (3-17-22)

~~b.~~ Each suspected or confirmed case of rabies in animals will be investigated to determine if potential human or animal exposure has occurred and identify persons who may need to undergo rPEP. (3-17-22)

~~c.~~ Each reported rPEP series initiation must be investigated to determine if additional individuals require rPEP and identify the source of possible rabies exposure. (3-17-22)

~~03. Handling of Report.~~ The Health District must notify the Department within one (1) working day of each reported case of this disease. (3-17-22)

~~042. Management of Exposure to Rabies.~~ All human exposures to a suspected or confirmed rabid animal must be managed as described under the guidelines presented in the “Human Rabies Prevention—United States” incorporated by reference in Subsection 004.03 of these rules and “Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices” incorporated by reference in Subsection 004.07 in these rules. Animals involved with bites, or themselves bitten by a suspected or confirmed rabid animal, must be managed under the guidelines in the “Compendium of Animal Rabies Prevention and Control,” incorporated by reference in Subsection 004.05 of these rules, and as described in Subsections 610.04.a., 610.04.b., and 610.04.c. of this rule. In the event that a human or animal case of rabies occurs, any designated representative of the Department, Health District, or Idaho State Department of Agriculture, will establish such isolation and quarantine of animals involved as deemed necessary to protect the public health. (3-17-22)()

a. The management of a rabies-susceptible animal that has bitten or otherwise potentially exposed a person to rabies must be as follows: (3-17-22)

i. Any livestock that has bitten or otherwise potentially exposed a person to rabies will be referred to the Idaho State Department of Agriculture for management. (3-17-22)

ii. Any healthy domestic dog, cat, or ferret, regardless of rabies vaccination status, ~~that has bitten or otherwise potentially exposed a person to rabies must be confined and observed for illness daily for ten (10) days following the exposure~~ **must be** under the supervision of a licensed veterinarian or other person designated by the Idaho State Department of Agriculture, Health District, or the Department. ~~If signs suggestive of rabies develop, immediately consult the Health District or Department to discuss euthanasia and rabies testing.~~ (3-17-22)()

iii. Any domestic dog, cat, or ferret that cannot be managed as described in ~~Subsection 610.04.a.ii. of this rule~~ must be destroyed by a means other than shooting ~~or other trauma in to~~ the head. The head must be submitted to an approved laboratory for rabies analysis. (3-17-22)()

iv. It is the animal owner's responsibility to follow instructions provided for the management of the animal. (3-17-22)

v. Rabies susceptible animals other than domestic dogs, cats, or ferrets must be destroyed and the head submitted to an approved laboratory for rabies analysis, unless an exemption is given by the Department or Health District. (3-17-22)

vi. No person will destroy, or allow to be destroyed, the head of a rabies-susceptible animal that has bitten or otherwise potentially exposed a person to rabies without authorization from the Department or Health District. (3-17-22)

b. The management of a rabies-susceptible animal that has not bitten a person, but has been bitten, mouthed, mauled by, or closely confined in the same premises with a confirmed or suspected rabid animal must be as follows: (3-17-22)

i. Any exposed livestock will be referred to the Idaho State Department of Agriculture for management. (3-17-22)

ii. Any domestic dog, cat, or ferret that has never been vaccinated against rabies as recommended by the American Veterinary Medical Association, must be **euthanized or** appropriately vaccinated in accordance with guidance in the "Compendium of Animal Rabies Prevention and Control" ~~incorporated by reference in Subsection 004.05 of these rules as soon as possible and placed in strict quarantine for a period of four (4) months (six (6) months for ferrets) and quarantined~~ under the observation of a licensed veterinarian or a person designated by the Idaho State Department of Agriculture, Health District, or the Department. ~~The strict q~~ Quarantine of such an animal must be within an enclosure deemed adequate by a person designated by the Idaho State Department of Agriculture, Health District, or the Department ~~to prevent contact with any person or rabies-susceptible animal~~. If signs suggestive of rabies develop, **the managing veterinarian or other designee must** immediately consult the Health District or Department to discuss euthanasia or rabies testing. ~~Destruction of such an animal is permitted as an alternative to strict quarantine.~~ (3-17-22)()

iii. An animal considered currently vaccinated against rabies, or overdue for rabies vaccination but with documentation of at least one (1) prior rabies vaccination, should be revaccinated against rabies as soon as possible with an appropriate vaccine, kept under the owner's control, and observed for illness for forty-five (45) days. If signs suggestive of rabies develop, **the owner must** immediately consult the Health District or Department to discuss euthanasia and rabies testing. These provisions apply only to animals for which an approved rabies vaccine is available. ~~Animals should be managed in accordance with guidance in the "Compendium of Animal Rabies Prevention and Control" incorporated by reference in Subsection 004.05 of these rules to conduct serological monitoring when a previous vaccination may have been received, but the documentation is unavailable. If evidence of previous vaccination cannot be demonstrated, the animal must be managed as described in Subsection 610.04.b.ii. of this rule.~~ (3-17-22)()

iv. The owner of the animal is financially responsible for the cost of managing and testing of the animal ~~as described in Subsection 610.04.b. of this rule.~~ (3-17-22)()

c. Any rabies-susceptible animal other than domestic dogs, cats, ferrets, or livestock that are suspected of having rabies, or have been in close contact with an animal known to be rabid, must be ~~destroyed~~ ethanized, unless an exemption is granted by the Department or Health District. ()

d. Any rabies susceptible animal other than domestic dogs, cats, ferrets, or other livestock that are suspected of having rabies, or have been in close contact with an animal known to be rabid. The animal must be ethanized and tested by an approved laboratory for rabies if a person has been bitten or has had direct contact with the animal that might result in the person becoming infected ~~unless an exemption is granted by the Department or Health District.~~ (3-17-22)()

~~05. City or County Authority.~~ Nothing in these rules is intended or will be construed to limit the power of any city or county in its authority to enact more stringent requirements to prevent the transmission of rabies. (3-17-22)

~~611. --619. (RESERVED)~~

~~620. RELAPSING FEVER, TICK BORNE AND LOUSE BORNE.~~

~~01. Reporting Requirements.~~ Each case of tick-borne or louse-borne relapsing fever must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of tick-borne or louse-borne relapsing fever must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and whether transmission was from lice or ticks. (3-17-22)

~~621. --629. (RESERVED)~~

~~630. RESPIRATORY SYNCYTIAL VIRUS (RSV).~~

~~A laboratory director must report each detection of respiratory syncytial virus (RSV) infection to the Department or Health District within one (1) working day of identification.~~ (3-17-22)

~~631. --639. (RESERVED)~~

~~640. REYE SYNDROME.~~

~~01. Reporting Requirements.~~ Each case of Reye syndrome must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of Reye syndrome must be investigated to obtain specific clinical information and to learn more about the etiology, risk factors, and means of preventing the syndrome. (3-17-22)

~~641. --649. (RESERVED)~~

~~650. ROCKY MOUNTAIN SPOTTED FEVER.~~

~~01. Reporting Requirements.~~ Each case of Rocky Mountain spotted fever must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of Rocky Mountain spotted fever must be investigated to confirm the diagnosis, identify the source of infection, and determine if control measures should be initiated. (3-17-22)

~~651.~~ 659. (RESERVED)

660. RUBELLA - INCLUDING CONGENITAL RUBELLA SYNDROME.

~~01. Reporting Requirements.~~ Each case or suspected case of rubella or congenital rubella syndrome must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of rubella or congenital rubella syndrome must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify any contacts who are susceptible and pregnant, and document the presence of the congenital rubella syndrome. (3-17-22)

~~031. Restrictions - Daycare Facility.~~ A person who is diagnosed with rubella must not attend daycare or work in any occupation in which there is close contact with children in a daycare facility as long as the disease is in a communicable form. Infants with congenital rubella syndrome should be restricted from day care facilities until 2 clinical specimens obtained 1 month apart are negative for rubella virus. (3-17-22)()

~~04. Restrictions - Health Care Facility.~~ A person who is diagnosed with rubella must not work in any occupation in which there is close contact with other persons in a health care facility as long as the disease is in a communicable form. (3-17-22)

~~05. Restrictions - Schools.~~ A person who is diagnosed with rubella must not attend, be present, or work in any occupation in which there is close contact with children or other persons in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

~~062. Restrictions - Personal Contact.~~ A person who is diagnosed with rubella must not work in occupations in which there is close contact with women likely to be pregnant as long as the disease is in a communicable form. (3-17-22)()

661. -- 669. (RESERVED)

670. SALMONELLOSIS - INCLUDING TYPHOID FEVER.

~~01. Reporting Requirements.~~ Each case or suspected case of salmonellosis or typhoid fever must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of salmonellosis or typhoid fever must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and to identify contacts, carriers, and the source of infection. (3-17-22)

~~03. Handling of Report.~~ The Department and the Health District will exchange reported information within one (1) working day on any suspected or reported case. (3-17-22)

~~041. Restrictions - Chronic Carrier.~~ Chronic carriers, which are those who excrete *Salmonella* for more than one (1) year after onset, are restricted from working as food employees. Chronic carriers must not work in any occupation in which they provide personal care to children in daycare facilities, or to persons who are confined to health care facilities or residential care facilities, until *Salmonella* is not identified by a licensed laboratory in any of three (3) successive approved fecal specimens collected at least seventy-two (72) hours apart. (3-17-22)

~~052. Restrictions - Non-Typhi Salmonella.~~ (3-17-22)

a. A fecally incontinent person excreting non-Typhi *Salmonella* must not attend a daycare facility. (3-17-22)

b. A person excreting non-Typhi *Salmonella* must not work in any occupation in which they provide personal care to children in a daycare facility or provide personal care to persons confined to a health care facility, unless an exemption is obtained from the Department or Health District. (3-17-22)

c. A symptomatic food employee excreting non-Typhi *Salmonella* must be managed under the IDAPA 16.02.19, "Idaho Food Code." (3-17-22)

d. Before a person can attend or work in a daycare facility or a health care facility, or work as a food employee, the person must provide two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart, that fail to show *Salmonella*. (3-17-22)

e. The Department may withdraw this restriction on a case of non-Typhi *Salmonella* provided that the person is asymptomatic. (3-17-22)

f. Any member of a household in which there is a case of non-Typhi salmonellosis must not work as a food employee until the member provides at least one (1) approved fecal specimen that fails to show *Salmonella* upon testing by a licensed laboratory. (3-17-22)

063. Restrictions - Salmonella Typhi. (3-17-22)

a. Any person with typhoid fever will remain subject to the supervision of the Department until *Salmonella Typhi* is not isolated by a licensed laboratory from three (3) successive approved fecal specimens collected at least twenty-four (24) hours apart ~~and not earlier than one (1) month after onset, and at least forty-eight (48) hours after the last dose of antibiotics.~~ (3-17-22)()

~~b. A food employee excreting *Salmonella Typhi* must be managed under IDAPA 16.02.19, "Idaho Food Code."~~ (3-17-22)

~~eb.~~ Any member of a household in which there is a case of *Salmonella Typhi* must not work in the occupations described in ~~Subsection 670.05.d. of this rule~~ this Section until the member provides at least two (2) successive approved fecal specimens collected twenty-four (24) hours apart that fail to show *Salmonella* upon testing by a licensed laboratory. (3-17-22)()

~~dc.~~ All chronic carriers of *Salmonella Typhi* must abide by a written agreement called a typhoid fever carrier agreement. This agreement is between the chronic carrier and the Department or Health District. Failure of the carrier to abide by the carrier agreement may cause the carrier to be isolated under Section 065 of these rules. The carrier agreement requires: (3-17-22)

i. The carrier cannot work as a food employee; (3-17-22)

ii. Specimens must be furnished for examination in a manner described by the Department or Health District; and (3-17-22)

iii. The Department or Health District must be notified immediately of any change of address, occupation, and cases of illness suggestive of typhoid fever in their family or among immediate associates, while there is a chronic carrier under a typhoid fever carrier agreement. (3-17-22)()

~~ed.~~ Chronic carriers of typhoid fever may be released from carrier status when *Salmonella Typhi* is not identified by a licensed laboratory in any of six (6) consecutive approved fecal and urine specimens collected at least one (1) month apart. (3-17-22)

~~671. --679. (RESERVED)~~

680. SEVERE ACUTE RESPIRATORY SYNDROME (SARS).

~~01. Reporting Requirements.~~ Each case or suspected case of severe acute respiratory syndrome (SARS) must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of SARS must be investigated to confirm the diagnosis, review the travel and other exposure history, identify other persons potentially at risk, and identify the most likely source of

the infection. (3-17-22)

~~03. Isolation.~~ Recommendations for appropriate isolation of the suspected or confirmed case will be made by the Department or Health District. (3-17-22)

~~681.—689. (RESERVED)~~

690. SEVERE REACTION TO ANY IMMUNIZATION.

~~01. Reporting Requirements.~~ Each case or suspected case of a severe reaction to any immunization must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of severe reaction to any immunization must be investigated to confirm and document the circumstances relating to the reported reaction to the immunization. (3-17-22)

~~03. Handling of Report.~~ The Department and the Health District will exchange reported information within one (1) working day on any reported case. (3-17-22)

~~691.—699. (RESERVED)~~

700. SHIGELLOSIS.

~~01. Reporting Requirements.~~ Each case or suspected case of shigellosis must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

~~02. Investigation.~~ Each reported case of shigellosis must be investigated to confirm the diagnosis and identify clusters or outbreaks of the infection. An attempt must be made to identify contacts, carriers, and the source of the infection. (3-17-22)

~~03. Handling of Report.~~ The Department and the Health District will exchange reported information within one (1) working day on any suspected or reported case. (3-17-22)

~~04~~1. Restrictions - Daycare Facility. (3-17-22)

a. A person excreting *Shigella* must not attend a daycare facility while fecally incontinent. (3-17-22)

b. A person excreting *Shigella* must not work in any occupation in which they provide personal care to children in a daycare facility while the disease is present in a communicable form, unless an exemption is obtained from the Department or Health District. During an outbreak in a daycare facility, a cohort system may be approved. (3-17-22)

c. The Department or Health District may withdraw the daycare restriction when the person has provided two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart that fail to show *Shigella* upon testing by a licensed laboratory. (3-17-22)

~~05.~~ Exclusions — Food Service Facility. (3-17-22)

~~a.~~ A food employee excreting *Shigella* must be managed under IDAPA 16.02.19, “Idaho Food Code.” (3-17-22)

~~b.~~ The Department or Health District may withdraw the food service restriction when the employee has provided two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart that fail to show *Shigella* upon testing by a licensed laboratory. (3-17-22)

~~06~~2. Restrictions - Health Care Facility. (3-17-22)

a. A person excreting *Shigella* must not work in any occupation in which they provide personal care

to persons who are confined to a health care facility while the disease is present in a communicable form, unless an exemption is obtained from the Department or Health District. During an outbreak in a facility, a cohort system may be approved. (3-17-22)

b. The Department or Health District may withdraw the health care facility restriction when the employee has provided two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart that fail to show *Shigella* upon testing by a licensed laboratory. (3-17-22)

c. During an outbreak in a facility, a cohort system may be approved. (3-17-22)

073. Restrictions - Household Contacts. No member of a household, in which there is a case of shigellosis, may work in any occupations in ~~Subsections 700.04 through 700.06 of this rule~~ **this Section**, unless the Department or Health District approves and at least one (1) approved fecal specimen is negative for *Shigella* upon testing by a licensed laboratory. (3-17-22)()

701. -- 709. (RESERVED)

710. SMALLPOX.

~~**01. Reporting Requirements.** Each case or suspected case of smallpox must be reported to the Department or Health District immediately, at the time of identification, day or night. (3-17-22)~~

~~**02. Investigation.** Each reported case of smallpox must be investigated promptly to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection and susceptible contacts. (3-17-22)~~

~~**03. Restrictions—Daycare Facility.** (3-17-22)~~

~~**a.** A person diagnosed with smallpox must not attend a daycare facility as long as the disease is in a communicable form. (3-17-22)~~

~~**b.** In the event of an outbreak, the Department or Health District may exclude susceptible children and employees from daycare facilities where a case has been identified until adequate immunization is obtained or the threat of further spread is contained. (3-17-22)~~

~~**04. Restrictions—Health Care Facility.** A person diagnosed or suspected of having smallpox in a health care facility must be managed under the “Guideline for Isolation Precautions in Hospitals,” as incorporated in Section 004 of these rules. (3-17-22)~~

051. Restrictions - Public Gatherings. A person diagnosed with smallpox must not attend public gatherings as long as the disease is in a communicable form. (3-17-22)

~~**06. Restrictions—School.** (3-17-22)~~

~~**a.** A person diagnosed with smallpox, regardless of age, must not attend a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)~~

~~**b.** In the event of an outbreak, the Department or Health District may exclude susceptible children and employees from schools where a case has been identified until adequate immunization is obtained or the threat of further spread is contained under Section 33-512(7), Idaho Code. (3-17-22)~~

072. Restrictions - Working. A person diagnosed with smallpox must not work in any occupation as long as the disease is in a communicable form. (3-17-22)

711. --719. (RESERVED)

720. STREPTOCOCCUS PYOGENES (GROUP A STREP) INFECTIONS.

01. Reporting Requirements. Each case of *Streptococcus pyogenes* (group A strep) infection that is invasive or results in rheumatic fever or necrotizing fasciitis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

02. Investigation. Each reported case of *Streptococcus pyogenes* (group A strep) infection that is invasive or results in rheumatic fever or necrotizing fasciitis must be investigated to confirm the diagnosis, to determine if the infection is part of an outbreak, and to identify the source of the infection. (3-17-22)

03. Restrictions—Daycare Facility. An infected person must not attend or work in a daycare until twenty-four (24) hours has elapsed after treatment is initiated or until they are no longer infectious as determined by a physician, the Department, or Health District. (3-17-22)

04. Restrictions—Health Care Facility. An infected person must not work in a health care facility until twenty-four (24) hours has elapsed after treatment is initiated or until they are no longer infectious as determined by a physician, the Department, or Health District. (3-17-22)

05. Restrictions—School. An infected person must not attend or work in a private, parochial, charter, or public school until twenty-four (24) hours has elapsed after treatment is initiated or until the patient is no longer infectious as determined by a physician, the Department, or Health District. (3-17-22)

721.—729. (RESERVED)

730. SYPHILIS.

01. Reporting Requirements. Each case or suspected case of syphilis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

02. Investigation. Each reported case of primary, secondary, or early latent syphilis must be investigated by the Department or Health District. Each person diagnosed with primary, secondary, or early latent infectious syphilis is required to inform all sexual contacts that they may have been exposed to a sexually transmitted infection, or provide sufficient information to public health officials so they may locate contacts and ensure that each is offered prompt diagnosis and treatment under Section 39-605, Idaho Code. (3-17-22)

03. Testing Without an Informed Consent. A physician may order blood tests for syphilis when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. (3-17-22)

731.—739. (RESERVED)

740. TETANUS.

01. Reporting Requirements. Each case of tetanus must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

02. Investigation. Each reported case of tetanus must be investigated to confirm the diagnosis and to determine the immunization status of the case. (3-17-22)

741.—749. (RESERVED)

750. TOXIC SHOCK SYNDROME.

01. Reporting Requirements. Each case of toxic shock syndrome must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

02. Investigation. Each reported case of toxic shock syndrome must be investigated to obtain specific clinical information on the syndrome and to determine the etiology, risk factors, and means of preventing the

syndrome. (3-17-22)

~~751.—759. (RESERVED)~~

~~760. TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES (TSE), INCLUDING CREUTZFELDT-JAKOB DISEASE (CJD) AND VARIANT CJD (vCJD).~~

~~01. Reporting Requirements. Each case or suspected case of transmissible spongiform encephalopathy (TSE), including Creutzfeldt-Jakob disease (CJD) and variant CJD (vCJD) must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation. Each reported case of transmissible spongiform encephalopathy (TSE) must be investigated to determine the cause and confirm the diagnosis. (3-17-22)~~

~~03. Autopsy. The state epidemiologist may order an autopsy for suspected CJD or vCJD deaths as per Section 39-277, Idaho Code. (3-17-22)~~

~~761.—769. (RESERVED)~~

~~770. TRICHINOSIS.~~

~~01. Reporting Requirements. Each case of trichinosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation. Each reported case of trichinosis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection. (3-17-22)~~

~~03. Handling of Report. The Department will notify the Idaho Department of Agriculture and other regulatory agencies as applicable. (3-17-22)~~

~~771.—779. (RESERVED)~~

~~780. TUBERCULOSIS.~~

~~01. Reporting Requirements. Each case of tuberculosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation. Each reported case of tuberculosis must be investigated to confirm the diagnosis, identify contacts, associated cases, and the source of the infection. (3-17-22)~~

~~03. Active Pulmonary Tuberculosis - Definition. Tuberculosis disease of the lungs, determined by a physician to be potentially contagious by clinical or bacteriological evidence or by evidence of the spread of the disease to others. Tuberculosis is considered active until cured. (3-17-22)~~

~~04. Cure of Tuberculosis - Definition. The completion of a course of antituberculosis treatment. (3-17-22)~~

~~05. Restrictions - Daycare Facility. A person with active pulmonary tuberculosis must not attend or work in any occupation in which they have direct contact or provides personal care to children in a daycare facility, until they are determined to be noninfectious by a licensed physician, the Department, or Health District. (3-17-22)~~

~~06. Restrictions - Health Care Facility. (3-17-22)~~

~~a. A person suspected to have pulmonary tuberculosis in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules, until the diagnosis of active pulmonary tuberculosis is excluded by a licensed physician. (3-17-22)()~~

b. A person with active pulmonary tuberculosis in a health care facility must be managed under the “Guideline for Isolation Precautions in Hospitals,” ~~as incorporated in Section 004 of these rules,~~ until they are determined to be noninfectious by a licensed physician, the infection control committee of the facility, or the Department. (3-17-22)()

c. A person with active pulmonary tuberculosis must not work in any occupation in which they have direct contact or provides personal care to persons confined to a health care or residential care facility, until they are determined to be noninfectious by a licensed physician, infection control committee of the facility, or the Department. (3-17-22)

d. In the event that active pulmonary tuberculosis is diagnosed in an employee, patient, or resident, the health care facility must conduct an investigation to identify contacts. The Department or Health District may assist in the investigation. (3-17-22)

074. Restrictions - School. A person with active pulmonary tuberculosis must not attend or work in any occupation in which they have direct contact with students in a private, parochial, charter, or public school until they are determined to be noninfectious by a licensed physician, the Department, or Health District. (3-17-22)

085. Restrictions - Household Contacts. Any member of a household, in which there is a case of active pulmonary tuberculosis, must not attend or work in any occupation in which they provide direct supervision of students in a school, personal care to children in a daycare facility or persons confined to a health care facility, or works in a food service facility, until they have been determined to be noninfectious by a licensed physician, the Department, or Health District. (3-17-22)

~~781. --789. (RESERVED)~~

~~790. TULAREMIA.~~

~~01. Reporting Requirements.~~ Each case or suspected case of tularemia must be reported to the Department or Health District immediately, at the time of identification, day or night. (3-17-22)

~~02. Investigation.~~ Each reported case of tularemia must be investigated to confirm the diagnosis and to identify the source of the infection. (3-17-22)

~~03. Handling of Report.~~ The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of the infection. (3-17-22)

~~791. --809. (RESERVED)~~

~~810. YERSINIOSIS, OTHER THAN PLAGUE.~~

~~01. Reporting Requirements.~~ Each case of yersiniosis, other than plague, must be reported to the Department or Health District within three (3) working days of identification. Plague must be reported immediately as described in Section 550 of these rules. (3-17-22)

~~02. Investigation.~~ Each reported case of yersiniosis must be investigated to confirm the diagnosis, identify carriers, and the source of the infection. (3-17-22)

~~03. Restrictions -- Food Service Facility.~~ A symptomatic person must be managed under IDAPA 16.02.19, “Idaho Food Code.” (3-17-22)

~~811. --949. (RESERVED)~~

~~DELEGATION OF POWERS AND DUTIES~~
~~(Sections 950-999)~~

~~950. DELEGATION OF POWERS AND DUTIES.~~

~~The Director has the authority to delegate to the Health Districts any of the powers and duties created by these rules under Section 39-414(2), Idaho Code. Any delegation authority will be in writing and signed by both the Director and the Health District Board.~~
(3-17-22)

~~951.~~ 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.27 – IDAHO RADIATION CONTROL RULES

DOCKET NO. 16-0227-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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) 56-1003, Idaho Code, and 56-1007, 56-1041, 56-1043, 56-1044, and 56-1046.

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. 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 4th, 2025, Idaho Administrative Bulletin, [Vol. 25-6, pages 88 through 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:

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.

DATED this 8th day of July, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 56-1003, Idaho Code, and 56-1007, 56-1041, 56-1043, 56-1044, and 56-1046.

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

VIRTUAL TELECONFERENCES Via WebEx
Wednesday, June 11, 2025 9:00 AM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m01fcd4491a48a596c81df58ce05f195c Join by meeting number Meeting number (access code): 2830 144 4738 Meeting password: bMyb9qWJM33 Meeting password when dialing from a phone or video system: 26929795 Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)
Tuesday, June 17, 2025 2:00 PM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=mda6f340678aa8ccb36168bac6c83bfe0 Join by meeting number Meeting number (access code): 2819 064 2981 Meeting password: WmWTKTPQ236 Meeting password when dialing from a phone or video system: 96985877 Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)

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:

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 19 and 20](#).

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 Jared Larsen at DHWRules@dhw.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 June 25th, 2025.

DATED this 2nd day of May, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0227-2501

16.02.27 – IDAHO RADIATION CONTROL RULES

000. LEGAL AUTHORITY.

~~The Idaho Legislature, under the following Sections of statute has granted authority to the Board of Health and Welfare and the Director of the Department to adopt rules related to x-ray producing machines in order to protect the health of the people of Idaho. Sections 56-1041 and 56-1043, Idaho Code, grant authority to the Board of Health and Welfare to adopt radiation control rules. Section 56-1041, Idaho Code, establishes the Department as the designated agency to regulate, license, and control radiation associated with x-ray machines. Section 56-1044, Idaho Code, requires that radiation machines for mammography be registered with the Department, as provided in rule. Section 56-1046, Idaho Code, grants authority to the Department to establish record-keeping and reporting requirements for those who possess or use an x-ray machine. Section 56-1003, Idaho Code, grants authority to the Director to supervise and administer laboratories. Section 56-1007, grants authority to the Department to charge and collect fees established by rule.~~ This chapter is adopted under the legal authority of Sections 56-1003, 56-1007, 56-1041, 56-1043, 56-1044, and 56-1046, Idaho Code. (3-15-22)()

001. TITLE AND SCOPE.

01. Title. ~~These rules are titled IDAPA-16.02.27, "Idaho Radiation Control Rules."~~ (3-15-22)

02. Scope. ~~Except as otherwise specifically provided, these rules apply to all persons who possess, use, transfer, own, or acquire any radiation machine~~ To define licensure, education, quality assurance, and safety

requirements for X-ray machines.

(3-15-22)()

002.—003. (RESERVED)

004. INCORPORATION BY REFERENCE.

The documents referenced in Subsections 004.01 through 004.03 of this rule are used as a means of further clarifying these rules. These documents are incorporated by reference and are available online as provided, or may be reviewed at the Department of Health and Welfare, Idaho Bureau of Laboratories at 2220 Old Penitentiary Road, Boise, Idaho 83712-8299. (3-15-22)

01. ~~National Council of Radiation Protection (NCRP) Report No. 147.~~ National Council of Radiation Protection (NCRP) Report No. 147, entitled: “Structural Shielding Design and Evaluation for Medical Use of X-rays and Gamma Rays of Energies up to Ten (10) MeV,” issued November 19, 2004, by the National Council on Radiation Protection and Measurement. This document may be obtained from: NCRP Publications, 7910 Woodmont, Bethesda, MD 20814, e-mail: NCRPpubs@NCRPonline.org, phone: 1-301-657-2652, Ext. 14. (3-15-22)

02. ~~Mammography Quality Standards Act Regulations, Part 900.~~ The Mammography Quality Standards Act Regulations, Part 900, located at 21 CFR 900.12 as authorized by 21 U.S.C. 360i, 360nn, 374(e); and 42 U.S.C. 263b. A copy of these regulation may be ordered from the U.S. Food and Drug Administration, 10903 New Hampshire Avenue, Silver Spring, MD 20993, phone: 1-888-INFO-FDA (1-888-463-6332). These regulations are available online at <http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/ucm110906.htm#s9001>. (3-15-22)

03. ~~Suggested State Regulations for Control of Radiation, Volume 1.~~ This publication is being adopted with the exclusions, modifications, and additions listed below in Subsections 004.03.a through 004.03.k of this rule. Suggested State Regulations for Control of Radiation, Volume 1, is published by the Conference of Radiation Control Program Directors, Inc., 1030 Burlington Lane, Suite 4B, Frankfort, Kentucky 40601. It is also available online at <https://www.crepcd.org/page/SSRCRs>. (3-15-22)

a. ~~Part A — General Provisions (March 2003).~~ Modifications have been made to this Part. See Sections 100–199 of these rules. (3-15-22)

b. ~~Part B — Registration [Licensure] of Radiation Machine Facilities, [Services]—And Associated Healthcare Professionals (February 2009).~~ Exclusions and modifications have been made to this Part. See Sections 200–299 of these rules. (3-15-22)

c. ~~Part C — Licensing of Radioactive Material (March 2010).~~ This Part is excluded from incorporation. (3-15-22)

d. ~~Part D — Standards for Protection Against Radiation (March 2003).~~ The following Sections of this Part are incorporated: 1101a, 1101b, 1101e, 1201a, 1201b, 1201e, 1201f, 1206, 1207, 1208, 1301, 1501, 1502, 1503, 1601, 1602, 1901, 1902, 1903, 1904e, 2102, 2103a, 2104, 2105, 2106, 2107a, 2110, 2201, 2202, 2203, 2204, 2205, and 2207b. (3-15-22)

e. ~~Part E — Radiation Safety Requirements for Industrial Radiographic Operations (February 1999).~~ Exclusions have been made to this Part. See Sections 400–499 of these rules. (3-15-22)

f. ~~Part F — Diagnostic X-rays and Imaging Systems in the Healing Arts (May 2009).~~ This Part is incorporated with no exclusions, modifications, or additions. (3-15-22)

g. ~~Part G — Use of Radionuclides in the Healing Arts (March 2003).~~ This Part is excluded from incorporation. (3-15-22)

h. ~~Part H — Radiation Safety Requirements for Analytical X-ray Equipment (January 1991).~~ This Part is incorporated with no exclusions, modifications, or additions. (3-15-22)

i. ~~Part I — Radiation Safety Requirements For Particle Accelerators (January 1991).~~ This Part is

excluded from incorporation. (3-15-22)

~~j.~~ Part J— Notices, Instructions and Reports to Workers; Inspections (March 2003). This Part is incorporated with no exclusions, modifications, or additions. (3-15-22)

~~k.~~ Parts M through Z. These Parts are excluded from incorporation. (3-15-22)

005.—049. (RESERVED)

050. LICENSING.

Sections 050 through 099 of these rules provide for the licensing of radiation machines. (3-15-22)

051. MACHINES REQUIRED TO BE LICENSED.

Radiation producing machines, unless exempt under Section B.4 of the Suggested State Regulations for Control of Radiation incorporated under Section 004 of these rules, must be licensed with the Radiation Control Agency in accordance with the requirements of Sections B.6 through B.9, of the Suggested State Regulations for Control of Radiation, as applicable. (3-15-22)

052. FEES.

01. Radiation Licensing Fees. Radiation facility fees apply to each person or facility owning, leasing, storing, or using radiation producing machines. This fee is assessed on the same cycle as inspections and consists of a base licensing fee and a per tube charge. Fees are due within thirty (30) calendar days of the renewal date. A late charge of fifty (\$50) dollars will be assessed at thirty one (31) days past the renewal date. If the fees are not paid by day ninety one (91) past the renewal date, licensure will be terminated.

X-Ray Renewal Cycle and Facility Fees			
Facility Type	Renewal Cycle	Facility Fee	Per Tube Fee
Hospital, Clinic, Medical Practice	2 Years	\$50	\$25
Dental, Chiropractic, Podiatric, Veterinary Practice	4 Years	\$50	\$25
Industrial, research, academic/ educational, or security	10 Years	\$50	\$25

(3-15-22)

02. X-Ray Shielding Plan Review and Fee. Facilities housing X-ray producing devices and regulated under these rules must obtain a review of their shielding plan by a qualified expert. A copy of this review, to include a floor plan and site specific shielding calculations, must be submitted to the Radiation Control Agency within thirty (30) days of receipt. Facilities may request a departmental review of the X-ray shielding calculations and floor plan by the Radiation Control Agency. A three hundred fifty dollar (\$350) fee will be charged for this service. (3-15-22)

03. Radiation Safety Program Fee. If a facility or group of facilities under one administrative control employs one (1) or more full-time individuals whose positions are entirely devoted to in-house radiation safety, the facility may pay a flat annual facility fee of one thousand dollars (\$1,000) instead of the licensing fees required in Subsection 052.01 of this rule. In addition, annual submittal of documentation of evidence of an ongoing and functioning quality control program must be submitted for review and approval. (3-15-22)

053. APPLICATION FOR LICENSE.

In addition to the requirements detailed in the incorporated reference, Section B, the following is required with application for use of x-ray producing devices. (3-15-22)

01. Responsible Authority. All applications must be signed by the responsible authority (RA) over the

x-ray producing device. Required qualifications of the RA can be found in Section B.6c of the SSRCR. (3-15-22)

02. ~~Application For License.~~ Application for license must be on forms furnished by the Radiation Control Agency and must contain: (3-15-22)

a. Name of the owner, organization or person having administrative control and responsibility for use (responsible authority); and (3-15-22)

b. Address and telephone number where the machine is located; and if the radiation producing machine is used as a mobile device, a central headquarters must be used. (3-15-22)

c. A designation of the general category of use, such as dental, medical, industrial, veterinary, and research; and (3-15-22)

d. The manufacturer, model number, and type of machine; and (3-15-22)

e. Name of the radiation machine supplier, installer, and service agent. (3-15-22)

f. Name of an individual to be responsible for radiation protection, when applicable. (3-15-22)

03. ~~Qualifications for Authorized Operation, Service, and Repair of X-ray Machines.~~ The responsible authority must prohibit any person from operating, performing maintenance, or furnishing servicing or services to an x-ray producing machine under their authority that is not properly trained, certified, or licensed to do so. The responsible authority must obtain and retain documentation for a minimum of two (2) years that all operation, service, repair, and maintenance of x-ray producing machine(s) under their authority are done so by a qualified individual or entity. (3-15-22)

04. ~~Operator Qualifications.~~ No individual will be permitted to act as an operator of a particular machine until such individual has received an acceptable amount of training in radiation safety as it applies to that machine and is approved by the Radiation Protection Supervisor or Radiation Safety Officer. Operators will be responsible for: (3-15-22)

a. Keeping radiation exposure to himself and to others as low as is practical; (3-15-22)

b. Being familiar with safety procedures as they apply to each machine; (3-15-22)

c. Wearing of personnel monitoring devices, if applicable; and (3-15-22)

d. Notifying the Radiation Protection Supervisor or Radiation Safety Officer of known or suspected excessive radiation exposures to himself or others. (3-15-22)

05. ~~Minimum Safety Requirements.~~ Unless otherwise specified within these or the incorporated rules, the following are the minimum safety requirements for personnel acting as radiographers or radiographers assistants: (3-15-22)

a. Licensees must not permit any individuals to act as radiographers as defined in these rules until such individuals: (3-15-22)

i. Have received copies of and instructions in the licensee's operating and emergency procedures; and have demonstrated understanding thereof; and (3-15-22)

ii. Have been instructed in the subjects outlined in Subsection 053.06 of this rule, and have demonstrated understanding thereof; and (3-15-22)

iii. Have received copies of and instruction in the correct execution of these rules and have demonstrated understanding thereof; and (3-15-22)

- ~~iv. Have demonstrated competence to use the specific radiation machine(s), related handling tools, and survey instruments that will be employed in their assignment. (3-15-22)~~
- ~~v. Have demonstrated an understanding of the instructions in this section by successful completion of a written test and a field examination on the subjects covered. (3-15-22)~~
- ~~b. Licensees must not permit any individuals to act as a radiographer's assistant as defined in these rules until such individuals: (3-15-22)~~
- ~~vi. Have received copies of and instructions in the licensee's operating and emergency procedures; and have demonstrated understanding thereof; and (3-15-22)~~
- ~~vii. Have demonstrated competence to use under the personal supervision of the radiographer the radiation machine(s) and radiation survey instrument(s) that will be employed in their assignment. (3-15-22)~~
- ~~viii. Have demonstrated an understanding of the instructions in this section by successfully completing a written or oral test and a field examination on the subjects covered. (3-15-22)~~
- ~~c. Records of the above training, including copies of written tests and dates of oral tests and field examinations, must be maintained for inspection by the Radiation Control Agency for three (3) years following termination of employment. (3-15-22)~~
- ~~d. Each licensee must conduct an internal audit program to ensure that the Radiation Control Agency's conditions and the licensee's operating and emergency procedures are followed by each radiographer and radiographer's assistant. These internal audits must be performed at least quarterly, and each radiographer must be audited at least annually. Records of internal audits must be maintained for inspection by the Agency for two (2) years from the date of the audit. (3-15-22)~~
- 06. Subjects to Be Covered During the Instruction of Radiographers. (3-15-22)**
- ~~a. Fundamentals of Radiation Safety, to include at least: (3-15-22)~~
 - ~~i. Characteristics of gamma and x-radiation; (3-15-22)~~
 - ~~ii. Units of radiation dose (millirem); (3-15-22)~~
 - ~~iii. Bioeffects of excessive exposure of radiation; (3-15-22)~~
 - ~~iv. Levels of radiation from radiation machines; (3-15-22)~~
 - ~~v. Methods of controlling radiation dose, including: (3-15-22)~~
 - ~~(1) Working time; (3-15-22)~~
 - ~~(2) Working distances; and (3-15-22)~~
 - ~~(3) Shielding; (3-15-22)~~
 - ~~vi. Radiation Protection Standards; (3-15-22)~~
- ~~b. Radiation Detection Instrumentation, to include at least: (3-15-22)~~
 - ~~i. Use of radiation surveys instruments, including: (3-15-22)~~
 - ~~(1) Operation; (3-15-22)~~
 - ~~(2) Calibration; and (3-15-22)~~

- (3) Limitations; (3-15-22)
- ii. Survey techniques; (3-15-22)
- iii. Use of Personnel Monitoring Equipment, including: (3-15-22)
- (1) Film badges, TLDs; (3-15-22)
- (2) Pocket dosimeters; and (3-15-22)
- (3) Pocket chambers; (3-15-22)
- e. Radiographic Equipment, to include operation and control of x-ray equipment; (3-15-22)
- d. The Requirements of Pertinent Federal regulations and State rules; (3-15-22)
- e. The Licensee's Written Operating and Emergency Procedures; and (3-15-22)
- f. Case histories of radiography accidents. (3-15-22)
- 07. ~~Modification, Revocation, and Termination of Licensees.~~** In accordance with amendments to the Act, departmental rules or regulations, or orders issued by the Radiation Control Agency, the terms and conditions of all licenses are subject to amendment, revision, or modification, and are subject to suspension or revocation. (3-15-22)
- ~~a. Any license can be revoked, suspended, modified, or denied, in whole or in part. (3-15-22)~~
- ~~i. For any materially false statement: (3-15-22)~~
- ~~(1) In the application; or (3-15-22)~~
- ~~(2) In any statement of fact required under provisions of the Act or under these rules; or (3-15-22)~~
- ~~ii. Because of conditions revealed: (3-15-22)~~
- ~~(1) Within the application; any report, record, or inspection; or (3-15-22)~~
- ~~(2) By any other means that would warrant the Radiation Control Agency to refuse to grant a license on an original application; or (3-15-22)~~
- ~~iii. For violations of or failure to observe any of the terms and conditions: (3-15-22)~~
- ~~(1) Of the Act; or (3-15-22)~~
- ~~(2) Of the license; or (3-15-22)~~
- ~~(3) Of any rule; or (3-15-22)~~
- ~~(4) Of any regulation; or (3-15-22)~~
- ~~(5) Of an order of the Radiation Control Agency. (3-15-22)~~
- ~~b. Except in cases of willful violation or in which the public health, interest or safety requires otherwise, no license can be modified, suspended, or revoked unless such issues have been called to the attention of the licensee in writing and the licensee afforded the opportunity to demonstrate or achieve compliance with all lawful requirements. (3-15-22)~~

~~08. **Emergency Action.** If the Radiation Control Program Director finds the public health, safety or welfare requires emergency action, the Director will incorporate findings in support of such action in a written notice of emergency revocation issued to the licensee. Emergency revocation is effective upon receipt by the licensee. Thereafter, if requested by the licensee in writing, the Director will provide the licensee a revocation hearing and prior notice thereof. Such hearings are conducted in accordance with IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ (3-15-22)

~~054.—099. (RESERVED)~~

~~100. **GENERAL PROVISIONS.**~~

~~Sections 100 through 199 of these rules will be used for exclusions, modifications, and additions to Part A of the Suggested State Regulations for Control of Radiation, Volume 1, as incorporated in Section 004 of these rules.~~ (3-15-22)

~~101. **SCOPE.**~~

~~Modification to Part A, Section A.1. Except as otherwise specifically provided, these regulations apply to all persons who receive, possess, use, transfer, own, or acquire any source of radiation; provided that nothing in these regulations applies to any person to the extent such person is subject to regulation by the Nuclear Regulatory Commission.~~ (3-15-22)

~~102. **DEFINITIONS.**~~

~~Additions to Part A, Section A.2.~~ (3-15-22)

~~01. **Act.** "Act" means Section 56-1053, Idaho Code.~~ (3-15-22)

~~02. **Agency.** "Agency" means the Idaho Department of Health and Welfare.~~ (3-15-22)

~~103. **VIOLATIONS.**~~

~~Modification to Part A, Section A.8. Any person who willfully violates any provision of the Act is subject to penalties under Section 56-1053, Idaho Code.~~ (3-15-22)

~~104. **IMPOUNDING.**~~

~~Modification to Part A, Section A.9. Sources of radiation are subject to impounding under Section 56-1052, Idaho Code.~~ (3-15-22)

~~105. **COMMUNICATIONS.**~~

~~Modification to Part A, Section A.12. All communications and reports concerning these rules, and applications filed under these rules, must be addressed to the Agency at Radiation Control Section, Idaho Department of Health and Welfare, Bureau of Laboratories, 2220 Old Penitentiary Road, Boise, Idaho 83712-8299.~~ (3-15-22)

~~106.—199. (RESERVED)~~

~~200. **LICENSURE OF RADIATION MACHINE FACILITIES, (SERVICES) AND ASSOCIATED HEALTHCARE PROFESSIONALS.**~~

~~Sections 200 through 299 of these rules will be used for exclusions, modifications, and additions to Part B of the Suggested State Regulations for Control of Radiation, Volume 1, as incorporated in Section 004 of these rules.~~ (3-15-22)

~~201. **LICENSURE OF RADIATION MACHINE FACILITIES.**~~

~~Exclusion to Part B, Section B.6. Subsection B.6.b is excluded from incorporation.~~ (3-15-22)

~~202. **RECIPROCAL RECOGNITION OF OUT OF STATE RADIATION MACHINES.**~~

~~Modifications and additions to Part B, Section B.16.~~ (3-15-22)

~~01. **Modification to Part B, Section B.16.a.iv.** States in which this machine is registered or licensed.~~ (3-15-22)

02. Addition to Part B, Section B.16—New Subsection d. The owner or person having possession of any radiation producing machine registered or licensed by a federal entity or state other than Idaho, or both, planning to establish regular operations in Idaho, must complete registration of the machine with the Agency within thirty (30) days after taking residence and prior to operation of the machine. Thirty (30) days prior to the expiration date of any out-of-state license for any radiation producing machine, the owner must apply to the Agency for a machine license. (3-15-22)

203.—399. (RESERVED)

400. RADIATION SAFETY REQUIREMENTS FOR INDUSTRIAL RADIOGRAPHIC OPERATIONS.
Sections 400 through 499 of these rules will be used for exclusions, modifications, and additions to Part E of the Suggested State Regulations for Control of Radiation, Volume 1, as incorporated in Section 004 of these rules. (3-15-22)

401. LICENSING AND REGISTRATION REQUIREMENTS FOR INDUSTRIAL RADIOGRAPHY OPERATIONS.
Exclusions to Part E, Section E.5. Subsections E.5.b.i and E.5.b.ii, are excluded from incorporation. (3-15-22)

402. LEAK TESTING AND REPLACEMENT OF SEALED SOURCES.
Part E, Section E.10 is excluded from incorporation. (3-15-22)

403. QUARTERLY INVENTORY.
Part E, Section E.11 is excluded from incorporation. (3-15-22)

404. LABELING, STORAGE, AND TRANSPORTATION.
Exclusions to Part E, Section E.14. Subsections E.14.a, E.14.b, and E.14.d, are excluded from incorporation. (3-15-22)

405. CONDUCTING INDUSTRIAL RADIOGRAPHIC OPERATIONS.
Exclusion to Part E, Section E.15. Subsection E.15.d is excluded from incorporation. (3-15-22)

406. RECORDS OF LEAK TESTING OF SEALED SOURCES AND DEVICES CONTAINING DU.
Part E, Section E.27 is excluded from incorporation. (3-15-22)

407. RECORDS OF QUARTERLY INVENTORY.
Part E, Section E.28 is excluded from incorporation. (3-15-22)

408. UTILIZATION LOGS.
Part E, Section E.29 is excluded from incorporation. (3-15-22)

409. LOCATION OF DOCUMENTS AND RECORDS.
Exclusions to Part E, Section E.37. Subsections E.37.b.iii, E.37.b.xi, and E.37.b.xii are excluded from incorporation. (3-15-22)

410. NOTIFICATIONS.
Exclusions to Part E, Section E.38. Subsections E.38.a.i, and E.38.a.ii are excluded from incorporation. (3-15-22)

411. APPLICATION AND EXAMINATIONS.
Part E, Section E.39 is excluded from incorporation. (3-15-22)

412. CERTIFICATION IDENTIFICATION (ID) CARD.
Part E, Section E.40 is excluded from incorporation. (3-15-22)

413. RECIPROCITY.
Part E, Section E.41 is excluded from incorporation. (3-15-22)

~~414. SPECIFIC REQUIREMENTS FOR RADIOGRAPHIC PERSONNEL PERFORMING INDUSTRIAL RADIOGRAPHY.~~

~~Part E, Section E.42 is excluded from incorporation.~~

~~(3-15-22)~~

~~415.—599. (RESERVED)~~

~~600. NOTICES, INSTRUCTIONS AND REPORTS TO WORKERS; INSPECTIONS.~~

~~Sections 600 through 699 of these rules will be used for exclusions, modifications, and additions to Part J of the Suggested State Regulations for Control of Radiation, Volume 1, as incorporated in Section 004 of these rules.~~

~~(3-15-22)~~

002. DEFINITIONS.

01. Department. The Idaho Department of Health and Welfare. ()

02. Qualified Expert. An individual who meets nationally recognized radiation safety standards and has specific training in shielding design and X-ray safety. ()

03. Radiation Safety Program. A documented program that ensures compliance with radiation protection standards, including safety procedures, training and quality control. ()

003. LICENSE REQUIREMENTS AND APPLICATION.

01. Federal Facilities. All X-ray machines except those owned and operated at federal facilities or exempted under Section 56-1046(4), Idaho Code, must be licensed with the Department. ()

02. License Application. Facilities must complete a license application approved by the Department. ()

03. Insurance and Financial Responsibility. Applicants must provide documentation of adequate insurance coverage and financial responsibility to ensure compliance with safety standards and regulatory obligations. ()

004. LICENSE RENEWAL AND FEES.

01. License Renewal. X-ray licensees must comply with the renewal cycles and fees as determined in the following table:

X-Ray Renewal Cycle and Facility Fees			
Facility Type	Renewal Cycle	Base Fee	Per Tube Fee
Hospital, Clinic, Medical Practice	2 Years	\$50	\$25
Dental, Chiropractic, Podiatric, Veterinary Practice	4 Years	\$50	\$25
Industrial, research, academic/ educational, or security	10 Years	\$50	\$25

()

02. Licensing Fee Due Dates and Late Penalties. Fees are due within thirty (30) calendar days of the renewal date. A late fee of fifty (\$50) will be assessed at thirty-one (31) days past the renewal date. If the fees are not paid by day ninety-one (91) past the renewal date, licensure will be terminated. ()

03. Radiation Safety Program Flat Fee. A facility or group of facilities under one administrative

control that has a full-time in-house radiation safety program that includes X-ray machines, may pay a flat annual facility fee of one thousand dollars (\$1,000) instead of the base and per tube fees. Facilities must submit annual documentation of their quality assurance and quality control program for review by the Department. ()

04. Recognition of Other Licenses. The Department will recognize out-of-state or federally licensed X-ray machines until the next required renewal cycle, when such licenses meet equivalent safety and operational standards to minimize duplicative licensing requirements. Facilities with federal or out-of-state licenses must register with the Department within thirty (30) days. ()

005. X-RAY SHIELDING PLAN APPROVAL.

Facilities housing X-ray machines must have a qualified expert conduct a site-specific shielding plan. A copy of this plan, including the floor plan and site-specific shielding calculations, must be submitted to the Department within thirty (30) days before conducting imaging procedures on patients. ()

006. ON-SITE INSPECTION.

Qualified representatives of the Department are authorized to inspect the premises and operations of all licensed X-ray facilities to determine the adequacy of their shielding, quality control, quality assurance, safety, training, and other X-ray control programs. Department representatives will issue a written inspection report of findings, list items requiring a response, and specify the response timeframes required to maintain licensure. ()

007. X-RAY MACHINE QUALITY CONTROL AND QUALITY ASSURANCE.

01. Quality Control. Licensed facilities must follow all X-ray machine manufacturer's required quality control procedures. Quality control records must be available for review by the Department and retained for at least two (2) license renewal cycles. ()

02. Quality Assurance. Licensed facilities must have a written quality assurance plan documenting how quality control records are reviewed, safety procedures are followed, and X-ray machine operators are appropriately trained. ()

008. X-RAY MACHINE PERFORMANCE STANDARDS.

01. Radiation Output. X-ray machines must have a consistent radiation output within specified limits. ()

02. Image Quality. The machines must produce high-quality images with sufficient contrast, resolution, and minimal noise. ()

03. Safety Features. X-ray machines must include the following safety features: ()

a. Beam Limiting Devices: to restrict the X-ray beam to the area of interest and reduce patient exposure; ()

b. Warning Lights and Signals: to indicate when the machine is in operation; and ()

c. Interlocks: to prevent accidental exposure by ensuring that the X-ray beam is only activated when the machine is properly configured. ()

04. Maintenance and Calibration. Regular maintenance and calibration of X-ray machines are required to ensure they operate within specified performance standards. ()

05. Compliance. X-ray machines used for human imaging must comply with (a) or (b) and must comply with (c): ()

a. U.S. Food and Drug Administration (FDA): FDA regulations on radiation-emitting products. ()

b. International Electrotechnical Commission (IEC): IEC standards for medical electrical equipment. ()

c. Documentation of compliance should be maintained for two (2) license renewal periods and be made available for inspection by regulatory authorities. ()

009. X-RAY FACILITY AND OPERATOR TRAINING REQUIREMENTS.

01. Facility Requirements. Licensed facilities must: ()

a. Post notice standards for protection against radiation in the facility; ()

b. Keep radiation exposure as low as is practical; ()

c. Provide written, site-specific, emergency procedures; ()

d. Provide written, site-specific, safety procedures as they apply to each machine; ()

e. Provide written, site-specific, operating procedures as they apply to each machine; ()

f. Provide and document staff training; and ()

g. Ensure personnel wear monitoring devices, if applicable. ()

02. Operator Training Requirements. No individual will be permitted to operate an X-ray machine until they have completed training and proven competency in radiation safety topics. Licensed facilities must retain written training records for each X-ray machine operator. Training records for current and former X-ray operators must be made available upon request. Training records must be retained for a minimum of two (2) license renewal cycles. X-ray operator training must include the following topics: ()

a. Fundamental of radiation safety; ()

b. Characteristics of gamma and X-radiation; ()

c. Units of radiation dose (millirem); ()

d. Bioeffects of excessive exposure to radiation; ()

e. Levels of radiation emitted from X-ray machines; ()

f. Methods of controlling radiation dose including working time, distance, and shielding; ()

g. State and federal radiation protection standards; ()

h. Proper use of site-specific radiation survey instruments; ()

i. Use of personnel monitoring equipment; ()

j. Proper use of site-specific X-ray machines; and ()

k. Site-specific operating and emergency procedures. ()

010. LICENSE MODIFICATION, SUSPENSION, OR REVOCATION.

The Department may modify, suspend, or revoke an X-ray license if materially false statements are made by the licensee on the application, for failure to respond to inspection findings in a timely manner, or if the Department finds that the X-ray producing device is used in a fashion that endangers patients, facility staff, or the public. ()

~~601~~011. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.08 – TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO (TAFI) PROGRAM

DOCKET NO. 16-0308-2501 (ZBR CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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.

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 chapter is proposed to be repealed and replaced with Docket No. 16-0308-2502. Which has been reorganized into manageable sections and subsections, with duplicative and unnecessary language removed and combined with chapters 16.06.13 and 16.04.14. Any guidance already addressed in federal statute, the state plan, or operational procedures was eliminated to prevent redundancies and confusion. 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 July 2nd, 2025, Idaho Administrative Bulletin, [Vol. 25-7, page 59](#).

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.

DATED this 1st day of October, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 16th, 2025.

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

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

This chapter is proposed to be repealed and replaced with Docket No. 16-0308-2502. Which has been reorganized into manageable sections and subsections, with duplicative and unnecessary language removed and combined with chapters 16.06.13 and 16.04.14. Any guidance already addressed in federal statute, the state plan, or operational procedures was eliminated to prevent redundancies and confusion.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 21 and 22](#).

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 Jared Larsen at DHWRules@dhw.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 July 23rd, 2025.

DATED this 28th day of May, 2025.

IDAPA 16.03.08 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.08 – FEDERAL WELFARE PROGRAMS

DOCKET NO. 16-0308-2502 (ZBR NEW CHAPTER)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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.

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 chapter replaces what is proposed to be repealed in docket 16-0308-2501 and reorganizes it into manageable sections and subsections, with duplicative and unnecessary language removed. Any guidance already addressed in federal statute, the state plan, or operational procedures was eliminated to prevent redundancies and confusion.

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. Section 112 was amended to correct a term updated elsewhere in the rule. Sections 200 and 201 were amended to correct verbiage that clarifies the rule and is consistent with the State Plan. The complete text of the proposed rule was published in the July 2nd, 2025, Idaho Administrative Bulletin, [Vol. 25-7, pages 60 through 65](#).

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.

DATED this 1st day of October, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

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

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

VIRTUAL TELECONFERENCES Via WebEx
Thursday, July 10, 2025 10:30 AM (MT)
Join from the meeting link: https://idhw.webex.com/idhw/j.php?MTID=mdcbb6ce350662eb9c626ac43ee01125b
Join by meeting number: Meeting number (access code): 2828 184 2600 Meeting password: 8kJ43HfqUug Meeting password when dialing from a phone or video system: 85543437
Join by phone: +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)
Tuesday, July 15, 2025 3:00 PM (MT)
Join from the meeting link: https://idhw.webex.com/idhw/j.php?MTID=m8ead86ab7df3cadd38fc840c9702f8ca
Join by meeting number: Meeting number (access code): 2824 073 0884 Meeting password: Pn3KkJn2P9e Meeting password when dialing from a phone or video system: 76355562
Join by phone: +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)

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

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

This chapter replaces what is proposing to be repealed in 16-0308-2501 and reorganizes it into manageable sections and subsections, with duplicative and unnecessary language removed. Any guidance already addressed in federal statute, the state plan, or operational procedures was eliminated to prevent redundancies and confusion.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 21 and 22](#).

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 Jared Larsen at DHWRules@dhw.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 July 23rd, 2025.

DATED this 28th day of May, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0308-2502

Italicized red text that is *double underscored* indicates amendments to the proposed text as adopted in the pending rule.

16.03.08 – FEDERAL WELFARE PROGRAMS

000. LEGAL AUTHORITY.

Section 56-202, Idaho Code, the Low-Income Home Energy Assistance Act of 1981, 42 U.S.C Sections 8621 to 8629, and 45 CFR Parts 260 - 265. ()

001. SCOPE.

These rules provide standards for the administration of the Temporary Assistance for Needy Families (TANF) program and the Low-Income Home Energy Assistance Program (LIHEAP). These rules do not apply to the Emergency Assistance for Families in Idaho program. ()

002. -- 099. (RESERVED)

TANF PROGRAM
(Sections 100 – 199)

100. TANF ELIGIBILITY.

To be eligible for TANF, individuals must care for a dependent child or be pregnant and meet these requirements:

- ()
- 01. Application.** Submit a signed application; ()
- 02. Residency.** Individuals must reside in Idaho (absence allowed for up to one hundred and eighty (180) days), intend to remain, and not claim residency in another state; ()
- 03. Household Unit.** Only one (1) TANF cash benefit is allowed in the same month for the household unit; and ()
- 04. Other Benefits.** Households eligible for TANF may not also receive Aid to the Aged, Blind, and Disabled (AABD) cash or Foster Care payments. ()
- 101. MANDATORY TANF HOUSEHOLD MEMBERS.**
A household must include: ()
- 01. Dependent Children.** Children under the age of eighteen (18) who reside with a parent or caretaker relative, including siblings and half siblings, living in the same home. ()
- 02. Parents.** Individuals who have an eligible child living with them. ()
- 03. Pregnant Woman.** At least in the third trimester before the baby is due and is unable to work due to medical reasons. ()
- 04. Spouses.** A married spouse living in the home. ()
- 05. Caretaker Relative.** An adult family member (other than the parent) who is responsible for a dependent child. ()
- 102. INCOME AND RESOURCES.**
- 01. Income Determination.** Eligibility and benefit amounts are based on countable income and resources including those of ineligible household members as determined by the Department. ()
- 02. Caretaker Income.** When a caretaker relative is applying solely for a relative child, only the child's income is counted. ()
- 103. COOPERATION RESPONSIBILITY.**
The parent, or caretaker relative included in the grant, must cooperate with the Department to identify and locate any non-custodial parent, establish paternity, and establish, modify and enforce the child support order, unless good cause exists. ()
- 104. GOOD CAUSE FOR NOT COOPERATING.**
Good cause for not cooperating with Child Support Services (CSS) are limited to: ()
- 01. Rape or Incest.** Proof is provided that the child was conceived as a result of rape or incest. ()
- 02. Physical or Emotional Harm.** Proof is provided that the non-custodial parent may inflict physical or emotional harm to the children, the custodial parent, or the caretaker relative. ()
- 03. Minimum Information Cannot be Provided.** Substantial and credible proof is provided indicating the participant cannot provide the minimum information regarding the non-custodial parent. ()
- 105. – 110. (RESERVED)**
- 111. SUBSTANCE ABUSE SCREENING AND TESTING NOTICE AT APPLICATION.**
The Department will provide notice of substance abuse screening and possible testing to each TANF applicant.

()

01. Screening Requirement. The Department conducts substance abuse screening as a condition of receiving TANF cash assistance. ()

02. Testing Requirement. The Department conducts substance abuse testing as a condition for receiving TANF cash assistance, if screening indicates the applicant is engaged in, or at high risk of, substance abuse. ()

03. Treatment Requirement. Participants must enter a substance abuse treatment program and cooperate with treatment, if screening, assessment or testing shows them in need of substance abuse treatment. ()

112. INDIVIDUAL RESPONSIBILITY PLAN (IRP).

01. Individual Responsibility Plan. An Individual Responsibility Plan (IRP) must be negotiated and signed by the mandatory adult household members as defined in these rules, with all application activities completed before eligibility can be approved. The household must continue to comply with ongoing IRP requirements to remain eligible. ()

02. Modifications. If the participant cannot meet an IRP condition, the participant must notify the Department. The IRP may be renegotiated or modified when conditions change. ()

113. INTENTIONAL PROGRAM VIOLATIONS (IPV).

If an individual commits IPV the Department will take all reasonable steps to recover the overpayment from the responsible individual. ()

114. SANCTIONS FOR NON-COMPLIANCE.

01. Applicant Voluntary Quit. An adult household member who quits a 20+ hour/week job within 60 days of application without good cause results in 90 days of ineligibility. ()

02. Striking. If any adult household member is on strike, the entire household is ineligible. ()

03. Work Activity Noncompliance. Failure to meet work activity requirements in the IRC, without good cause, counts as an occurrence. Penalties are based on the number of occurrences as follows: ()

a. First Occurrence. The household is ineligible for one (1) month or until compliance, whichever is longer. ()

b. Second Occurrence. The household is ineligible for three (3) months or until compliance, whichever is longer. ()

c. Third Occurrence. The household permanently is ineligible. ()

04. Work Activity Penalties. Work activity penalties are applied as follows: ()

a. Individual Penalty. Penalties for individuals count towards an individual's total number of sanctions. Any household an individual resides in during the period is subject to the penalty period. ()

b. Child Work Activity Penalty. A fifty-dollar (\$50) penalty per month, per child sixteen (16) years of age or older, will be subtracted from the household grant if they do not meet work activity requirements while living in the household. ()

c. School Attendance Penalty. A fifty dollar (\$50) monthly deduction per child applies if school-age children fail to attend school, unless participating in IRP-approved work activities. ()

05. Paternity. If the grant is reduced by fifty percent (50%) for failure to establish paternity within twelve (12) months, child support penalties apply first before school or work penalties. ()

06. IRP Noncompliance. Failing to meet IRP requirements without good cause will result in applicable penalties. ()

115. OVERPAYMENT.

In the event of an overpayment the participant will be notified of the overpayment including details on the recovery process, hearing rights, repayment methods, and the need to schedule a repayment interview. ()

116. – 199. (RESERVED)

**LIHEAP
(Sections 200 – 299)**

200. LIHEAP ELIGIBILITY.

To be eligible for LIHEAP, households must meet the following requirements: ()

01. Application. Submit a signed application or have active Supplemental Nutrition Assistance Program (SNAP) benefits in the current LIHEAP season (October to September); ()

02. Citizenship. Meet citizenship eligibility requirements; ()

03. Income. Meet income eligibility requirements; ()

04. Residency. Reside in Idaho; ()

05. Verifications. Provide requested verifications; ()

06. Benefits. Only one (1) LIHEAP regular assistance benefit and one (1) LIHEAP Crisis benefit per LIHEAP season; ()

07. Responsibility. A household member is responsible for home energy costs and incur the costs either directly or as a designated portion of their rent; and ()

08. Federal Income. Households in which one (1) or more individuals are receiving Supplemental Security Income (SSI) under Title XVI of the Social Security Act, SNAP, or means tested Veterans Affairs (VA) benefits are eligible for LIHEAP. ()

201. MANDATORY LIHEAP HOUSEHOLD MEMBERS.

All individuals or groups of individuals who are living together as one economic unit for whom residential energy is customarily purchased in common or who make designated payments for energy as a portion of rent. ()

202. INCOME.

Gross income is counted for all household members, including income from ineligible household members, as determined by the Department. ()

203. OVERPAYMENTS.

In the event of an overpayment, the participant will be notified of the overpayment, including details on the recovery process, hearing rights, and repayment methods. ()

204. RECOUPMENT OF OVERPAYMENT.

The Department will take all reasonable steps to recover the overpayment from the responsible individual who provided intentionally false or misleading information to obtain program eligibility. ()

205. PROVISIONS CONTINGENT UPON FEDERAL FUNDING.

This program is contingent upon availability and receipt of funds appropriated through federal legislation. When

federal funds are not available, these provisions or any part therein are considered dormant; there may be no advance notice of termination or reduction of benefits. If additional funds are available, a supplemental payment may be made at the discretion of the Administrator. ()

206. – 999. (RESERVED)

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

[LINK: LSO Rules Analysis Memo](#)

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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-202, Idaho Code, and Sections 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

VIRTUAL TELECONFERENCE Via WebEx
Wednesday, September 17, 2025 1:00 PM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m783dd6ad225883ef0ce90968fcf16cee
Join by meeting number Meeting number (access code): 2818 917 5847 Meeting password: JebRQNsa767 Meeting password when dialing from a phone or video system: 53277672
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)

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:

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 one chapter for all of Medicaid, and then a separate independent chapter, this chapter is being repealed and consolidated into the overall Medicaid chapter 16.03.26.

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

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 resulting from this rulemaking:

There will not be an impact to the General Fund greater than \$10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because there was not sufficient time for negotiated rulemaking after passage of HB345 during the 2025 Legislative Session.

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 Jared Larsen at 208-334-5500.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 24, 2025.

DATED this 20th day of August, 2025.

IDAPA 16.03.13 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.21 – DEVELOPMENTAL DISABILITIES AGENCIES (DDA)

DOCKET NO. 16-0321-2501 (CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 39-4605, 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 chapter is a consolidation of IDAPA 16.03.21 (Developmental Disabilities Agencies) and IDAPA 16.04.17 (Residential Habilitation Agencies). Consolidating these two chapters will assist the Department and providers with efficiency and consistency while reducing regulatory burden and ensure the health and safety of the vulnerable individuals these organizations serve. This chapter includes requirements for Adult Residential Care Facilities that provides residential services to adult individuals with developmental disabilities.

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 4th, 2025, Idaho Administrative Bulletin, [Vol. 25-6, pages 101 through 125](#).

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.

DATED this 8th day of July, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 39-4605, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Monday, June 9, 2025 2:00 PM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m3b53e9aad0b5c7a8406b205b66d2e692
Join by meeting number Meeting number (access code): 2820 182 3802 Meeting password: TpZmsjq2e86 Meeting password when dialing from a phone or video system: 87967572
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)
Friday, June 20, 2025 2:00 PM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m909cd0ca85fdb797c81a68a9b3ffbee3
Join by meeting number Meeting number (access code): 2830 045 5205 Meeting password: YBpf4VRZe83 Meeting password when dialing from a phone or video system: 92734879
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)

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

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

This chapter is a consolidation of IDAPA 16.03.21 (Developmental Disabilities Agencies) and IDAPA 16.04.17 (Residential Habilitation Agencies). Consolidating these two chapters will assist the Department and providers with efficiency and consistency while reducing regulatory burden and ensure the health and safety of the vulnerable individuals these organizations serve. This chapter includes requirements for Adult Residential Care Facilities that provides residential services to adult individuals with developmental disabilities.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted for the consolidated document of both 16.04.17 and 16.03.21. Stakeholders were provided with the draft document showing the proposal to repeal 16.04.17 and insert components into 16.03.21. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 27 and 28](#).

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 Jared Larsen at DHWRules@dhw.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 June 25th, 2025.

DATED this 2nd day of May, 2025.

Italicized red text that is *double underscored* indicates amendments to the proposed text as adopted in the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0321-2501

16.03.21 – DEVELOPMENTAL DISABILITIES AGENCIES (DDA).
RESIDENTIAL HABILITATION AGENCIES, AND ADULT RESIDENTIAL CARE FACILITIES

000. LEGAL AUTHORITY.

Section 39-4605, Idaho Code, authorizes the Idaho Board of Health and Welfare to adopt rules and standards of certification for Developmental Disabilities Agencies, Residential Habilitation Agencies, and Adult Residential Care Facilities, to promote the health and safety of participants. These entities will be referred to as an organization for this rule chapter. (3-17-22)()

001. SCOPE.

These rules govern developmental disabilities agencies, residential rehabilitation agencies, and adult residential care facilities. (3-17-22)()

01. Certification. ~~The granting, denial, or revocation of certification is based on whether agencies are adequate for the health, safety, and the care, treatment, maintenance, training, and support of participants under these~~

rules. (3-17-22)

~~02. Application. Any person, corporation, or association may apply to the Department for approval and certification of the applicant's DDA.~~ (3-17-22)

002. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. **Verification of Compliance.** The ~~agency organization~~ must verify that all employees, subcontractors, agents of the ~~agency organization~~, and volunteers ~~delivering DDA services~~ have complied with IDAPA 16.05.06, "Criminal History and Background Checks." (3-17-22)()

~~02. Reporting Criminal Convictions, Pending Investigations, or Pending Charges. Once an employee, subcontractor, agent of the agency, or volunteer delivering DDA services has received a criminal history clearance, any additional criminal convictions, pending investigations, or pending charges must be reported to the Department as listed in IDAPA 16.05.06, "Criminal History and Background Checks," Subsections 210.01 and 02 by the close of the next business day when the agency learns of the convictions, investigations, or changes.~~ (3-17-22)

010. DEFINITIONS – A THROUGH Z.

For the purposes of this chapter of rules, the following terms apply. (3-17-22)

~~01. ADA. The "Americans with Disabilities Act Accessibility Guidelines," under 28 CFR Part 36, Appendix A.~~ (3-17-22)

~~02. Center-Based Services. Services provided in a location under control of the agency through ownership or lease agreement that meets requirements under Section 400 of these rules.~~ (3-17-22)

01. Abuse. The non-accidental act of sexual, physical, verbal, or mental mistreatment, or injury of a participant through the action or inaction of another individual. ()

02. Adult Residential Care Facility. A facility that provides any service or group of services which provide care to the developmentally disabled on an inpatient or residential basis. ()

03. Advocate. An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of developmentally disabled, mentally ill, or elderly participants. ()

~~034. Communicable Disease. A disease that may be transmitted from one (1) person or animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means that may result in infection, illness, disability, or death.~~ (3-17-22)

~~045. Deficiency. A determination of non-compliance with a specific rule or part of rule.~~ (3-17-22)

~~056. Department. The Idaho Department of Health and Welfare.~~ (3-17-22)

~~06. Developmental Disability. A developmental disability, defined in Section 66-402, Idaho Code.~~ (3-17-22)

07. **Developmental Disability Agency (DDA).** A business entity, ~~also known as "agency,"~~ that meets the definition of a developmental disabilities facility provided in Section 39-4604(3), Idaho Code, that is certified by the Department to provide services to eligible individuals ~~with developmental disabilities under these rules.~~ (3-17-22)()

08. Exploitation. An action that may include, but is not limited to, the unjust or improper use of a vulnerable participant's financial power of attorney, funds, property, or resources by another person for profit or advantage. ()

089. Health Care Professional. An individual licensed to provide health care within their respective discipline and scope of practice. (3-17-22)

09. ~~Implementation Plan.~~ A plan that details how goals from the plan of service will be accomplished. (3-17-22)

10. ~~Natural Setting.~~ The environment where an activity or behavior naturally occurs that is typical for peers of the participant's age, such as the home and community, where the participant lives or participates in activities, and in the service environment indicated. (3-17-22)

10. Immediate Jeopardy. A level of non-compliance with one (1) or more requirements in this chapter that has caused, or is likely to cause, serious injury, harm, impairment, or death to a participant that requires an immediate response. ()

11. Maladaptive Behavior. Any behavior that significantly interferes with participant care or presents a danger to self or others. ()

12. Medication. Any substance or drug used to treat a disease, condition, or symptoms that may be taken orally, injected, or used externally, and is available through prescription or over the counter. ()

13. Neglect. The failure to provide food, clothing, shelter, or medical care reasonably necessary to sustain the life and health of a vulnerable adult as defined in Section 18-1505, Idaho Code. ()

14. Participant. An individual receiving services through a DDA, Residential Habilitation Agency or Adult Residential Care Facility. (3-17-22)()

15. Residential Habilitation. Services consisting of an integrated array of individually tailored services and supports furnished to an eligible participant that are designed to assist them to reside successfully in their own home. Services include personal care services, and skill training. Individuals who provide residential habilitation services must be employed by a residential habilitation agency. ()

16. Physical Restraint. Any manual hold or mechanical device that the participant cannot remove easily, and which restricts the free movement of or normal functioning of any portions of a participant's body. ()

17. Plan of Service. An initial plan, annual plan, or addendum that identifies all services, ~~supports, or both, if applicable~~ offered. (3-17-22)()

18. Repeat Deficiency. ~~A violation or deficiency found on a resurvey or revisit to a DDA that was also found during the previous survey or visit~~ The Department has found an organization is out of compliance with a rule and received a citation on two (2) consecutive surveys. (3-17-22)()

19. Substantial Compliance. A level of compliance that has not or will not cause significant injury that requires medical attention to a participant. ()

20. Survey. A review conducted by the Department to determine compliance with statutes and rules. (3-17-22)

21. Time Out. A separate unlocked room or location, that is supervised, that is used to remove a participant from an activity that may be triggering or reinforcing maladaptive behavior. ()

011. --~~074.~~ (RESERVED)

SERVICES PROVIDED BY DEVELOPMENTAL DISABILITIES AGENCIES
Sections 075-099

~~075. DDA SERVICES.~~

A DDA provides services that include evaluation, diagnostics, skill development, intervention, and support services that are provided in the community, home, or center to individuals eligible to receive services. (3-17-22)

~~076.— 099. (RESERVED)~~

**~~CERTIFICATION REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES AGENCIES~~
~~Sections 100-299~~**

~~100. TYPES OF CERTIFICATES ISSUED~~CERTIFICATION REQUIREMENTS FOR DDA, RESIDENTIAL HABILITATION AGENCIES, AND ADULT RESIDENTIAL CARE FACILITIES.

The Department issues certificates in effect for a period no longer than three (3) years. The types of certificates issued are as follows: (3-17-22)

~~01. Initial Certificate.~~ When the Department determines application requirements have been met, an initial certificate is issued for a period of up to six (6) months from the initiation of services. The Department will survey the agency prior to the certificate expiration date to ensure substantial compliance with these rules. When the agency is determined to be in substantial compliance, a one (1) year certificate will be granted. (3-17-22)

~~02. One-Year Certificate.~~ A one (1) year certificate is issued by the Department when it determines the agency is in substantial compliance with these rules, following an initial or provisional certificate, or when there may be areas of deficient practice that would impact the agency's ability to provide adequate care. An agency is prohibited from receiving consecutive one (1) year certificates. (3-17-22)

~~03. Three-Year Certificate.~~ A three (3) year certificate is issued by the Department when it determines the agency requesting certification is in substantial compliance with these rules. (3-17-22)

~~04. Provisional Certificate.~~ When an agency is found to be out of substantial compliance with these rules but does not have deficiencies that jeopardize the health or safety of participants, a provisional certificate may be issued by the Department for up to a six (6) month period. (3-17-22)

~~a.~~ A provisional certificate is issued contingent upon the correction of deficiencies under a plan developed by the agency and approved by the Department. (3-17-22)

~~b.~~ Before the end of the provisional certification period, the Department will determine whether areas of concern have been corrected and whether the agency is in substantial compliance with these rules. (3-17-22)

~~c.~~ If the Department determines the agency is in compliance, a one (1) year certificate will be issued. If the agency is determined to be out of compliance, the certificate will be revoked. (3-17-22)

~~101. APPLICATION FOR INITIAL CERTIFICATION.~~

~~01. Certification Required.~~ Before any agency can operate and provide services as a DDA, it must apply for, obtain, and maintain DDA certification from the Department. (3-17-22)

~~02. Department Review Not Guaranteed.~~ The Department may choose not to consider the application of any operator, administrator, or owner of an agency whose license or certification has been revoked until five (5) years have lapsed from the date of revocation. (3-17-22)

~~03. Open Application.~~ An applicant may apply up to three (3) times within a three hundred sixty-five (365) day period starting on the date of the first submission. If the application is incomplete upon a third submission, the application will be denied. The applicant may not resubmit an application for six (6) months from the date of the denial notice. (3-17-22)

01. Application for Initial Certification. Certification will be issued to any organization upon completing an application demonstrating compliance with these rules ()

042. Content of Application for Certification. ~~The A~~application for certification must be submitted to the Department on the Department-approved form with the following information and supporting documents at least sixty (60) days prior to the planned opening must include: (3-17-22)()

~~a.~~ An application form that contains name, address, and telephone number of the agency, type of services to be provided, the geographic service area of the agencies, and the anticipated date for the initiation of services; (3-17-22)

~~ba.~~ An accurate and complete statement of all ~~b~~Business names of the agency organization as filed with the Secretary of State, whether it is an assumed business name, partnership, corporation, limited liability company, or other entity that identifies each owner and the management structure of the agency; (3-17-22)()

~~c.~~ A statement that the agency will comply with these rules and all other applicable local, state, and federal requirements, including an assurance that the agency complies with pertinent state and federal requirements governing equal opportunity and nondiscrimination; (3-17-22)

~~db.~~ A copy of the proposed ~~e~~Organizational chart or plan for staffing of the agency; (3-17-22)()

c. The following Policies and Procedures; ()

ei. Written policies and procedures addressing qualifications to meet service delivery requirements including resumes, job descriptions, verification of criminal history clearance, and copies of state licenses and certificates, when applicable Staff and volunteer qualifications including, roles, responsibilities and organization expectations; (3-17-22)()

fii. Written policies and procedures for the development and implementation of personnel training to meet the requirements of Section 302 of these rules Staff training that is specific and appropriate to the population served; (3-17-22)()

giii. Personnel and participant illness policy, communicable disease policy, and other health-related policies and procedures Infection prevention measures to mitigate the spread of communicable diseases; (3-17-22)()

iv. General health care services including assessment and treatment of acute and chronic complaints or situations. ()

hy. Written ~~t~~Transportation safety policies and procedures required in Section 402 of these rules, including the organization's preventive maintenance program, inspection intervals, insurance coverage, and licensed driver requirements for organization owned vehicles, and a policy for staff owned vehicles, if applicable; (3-17-22)()

vi. Written participant grievance policies and procedures to meet requirements in Section 406 of these rules The organization must ensure the participant and the guardian, if applicable, has been informed of how to file a grievance. The organization must respond to the grievance within fourteen (14) days or less; (3-17-22)()

jvii. Written medication policies and procedures to address medication standards to meet requirements in Section 405 of these rules Medication standards; (3-17-22)()

kviii. Written policies and procedures that address the development of positive behavior supports to meet requirements in Section 510 of these rules Behavior Management, including approved interventions to manage inappropriate or maladaptive behaviors, and restraints if applicable; (3-17-22)()

lix. Written policies and procedures for reporting incidents to the adult protection, child protection authority, or both, and to the Department to meet requirements in Section 404 of these rules Reporting incidents of abuse, neglect and exploitation including notifying the proper authorities; (3-17-22)()

x. Incident Reports for all events that occur during service delivery that interfere with the participants'

safety or ability to participate; ()

~~m.~~ A written code of ethics policy reflecting nationally recognized professional standards of practice. The policy must articulate basic values, ethical principles and standards for confidentiality, conflict of interest, exploitation, and inappropriate boundaries in an agency's relationship with participants, relatives, or with other agencies; (3-17-22)

~~n.~~ Complete administrator and supervisor records as required in Subsection 301.04 of these rules; (3-17-22)

~~o.~~ Sample of the following documents: (3-17-22)

~~i.~~ Complete participant record as required in Subsection 301.05 of these rules; (3-17-22)

~~ii.~~ Program billing; (3-17-22)

~~iii.~~ Quality assurance program developed to meet requirements in Section 500 of these rules; (3-17-22)

~~iv.~~ All documents referenced in the application. (3-17-22)

~~p.~~ Any other information requested by the Department for determining the agency's compliance of these rules or the agency's ability to provide the services for which certification is requested; (3-17-22)

xi. Termination of services that ensures the safety of the participant and notifies all relevant parties; ()

xii. The organization will only accept and retain participants for whom the organization has the appropriate staff and skills to provide the services; and ()

xiii. Each organization must ensure the rights provided under Section 66-412, Idaho Code, and will ensure the participant's privacy and confidentiality, promote independence in the community and allow participants to refuse services. ()

~~qd.~~ When center-based services are to be provided, the agency must include the following and meet requirements under Section 400 of these rulesDDA center and Adult Residential Care Facilities must include the following: (3-17-22)()

~~i.~~ Address and telephone number for each service location; (3-17-22)

~~ii.~~ Supporting documentation requirements including the ADA checklist, local fire safety inspection, and local building and zoning compliance"Americans with Disabilities Act Accessibility Guidelines," under 28 CFR Part 36, Appendix checklist, local fire safety inspection, and Certificate of Occupancy; and; (3-17-22)()

~~iii.~~ Written policies and procedures covering the protection of all individuals in the event of fire and other emergencies to include emergency evacuation procedures; andfor responding to fire, emergencies, including emergency evacuation plans. (3-17-22)()

~~iv.~~ A site review completed by the Department prior to the initiation of center-based services verifying compliance with these rules. (3-17-22)

03. Denial of an Application. The Department may deny any application for the following reasons; ()

a. The applicant is not in substantial compliance with these rules; ()

b. The applicant has willfully misrepresented or omitted information on the application; or ()

c. The administrator or owner of an organization whose certification has been revoked within the last five (5) years. ()

04. **Certificate.** The Department will issue an initial six (6) month certificate when it is determined the organization is in substantial compliance. Following the initial or a provisional certificate the Department will issue a one year (1-year) certificate, or as needed to determine compliance with rules. A three (3) year certificate is issued when it is determined the organization is in substantial compliance. ()

a. Application of renewal. An organization must apply to renew its certificate no less than sixty (60) days before the expiration date. ()

b. Expiration. Expiration of a certificate without a timely request for renewal rescinds the organization's certificate. ()

c. DDA Center and Adult Residential Care Facility, the certificate must be posted and visible to the public. ()

05. **Survey and Investigations.** ()

a. Investigation Survey. The Department will investigate complaints of alleged rule violations. Complainant information is kept confidential. ()

b. Method of Investigation. The Department will determine the method used to investigate the complaint. ()

c. Notification to Complainant. The Department will provide a written response to the complainant upon completion of the investigation. ()

d. Licensing and Certification will conduct survey and investigation at specified intervals to determine compliance with this chapter of rules and Title 66, Chapter 4, Idaho Code and Section 39-4605, Idaho Code. ()

06. **Notification To the Department.** ()

a. The Department must be notified when the organization's owner, administrator, service area, or address changes; and ()

b. New ownership, certificates are not transferable. ()

1021. -- 10916. (RESERVED)

~~**110. DEPARTMENT'S WRITTEN DECISION REGARDING APPLICATION FOR CERTIFICATION.** The Department will provide to the agency, within thirty (30) days of the date the completed application packet is received, a written decision regarding certification. An application is considered completed when all required documents are received and comply with these rules. (3-17-22)~~

~~**111. DENIAL OF AN APPLICATION.** The Department may deny any application. (3-17-22)~~

~~**01. Causes for Denial.** Causes for denial of an application may include: (3-17-22)~~

~~**a:** The application does not meet rule requirements in Subsection 101.04 of these rules; (3-17-22)~~

~~**b:** The applicant, owner, operator, or provider has: (3-17-22)~~

~~**i:** Willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a certificate; (3-17-22)~~

ii. Been denied or has had revoked any license or certificate for a DDA, facility, certified family home, or residential habilitation agency; or (3-17-22)

iii. Been convicted of operating an unlicensed or uncertified DDA, facility, certified family home, or residential habilitation agency; (3-17-22)

iv. A court order that mandates the applicant must not operate a DDA, facility, certified family home, or residential habilitation agency; (3-17-22)

v. An action, either current or in process, against a certificate held by the applicant either in Idaho or any other state or jurisdiction. (3-17-22)

02. Before Denial is Final. The Department will advise the individual or provider in writing of the denial and their right and method to appeal. Contested case hearings, including denial and revocation, must be conducted under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-17-22)

~~112.—114. (RESERVED)~~

~~115. CHANGES THAT REQUIRE REPORTING:~~

~~01. Notification To The Department.~~ (3-17-22)

~~a.~~ When a change of a certified agency's ownership, administrator, geographic service area, or address is contemplated, the owner or designee must notify the Division of Licensing and Certification in writing through the Department approved process. (3-17-22)

~~02. Center-Based Services.~~ When an agency plans to provide center-based services in a new physical location, on a temporary or permanent basis, the Department will conduct a site review within thirty (30) days after the agency has relocated. Included with the notification required under this rule, the agency must provide: (3-17-22)

~~a.~~ Evidence of review and approval by the local fire and building authorities, including issuance of occupancy permit; (3-17-22)

~~b.~~ A checklist that verifies compliance with the ADA requirements and Subsection 400.01 of these rules; and (3-17-22)

~~c.~~ Written policies and procedures covering the protection of all individuals in the event of fire and other emergencies to include emergency evacuation procedures. (3-17-22)

~~03. Updated Certificate Necessary.~~ To continue operation after any such anticipated change, the DDA must receive an updated certificate from the Department that reflects the change(s). An agency that fails to notify the Department of such changes is operating without a certificate. (3-17-22)

~~04. New Ownership.~~ For new ownership, the new owner must submit a new application to the Division of Licensing and Certification through the approved process at least sixty (60) days prior to the proposed date of change under Section 101 of these rules. (3-17-22)

~~116. CERTIFICATE NOT TRANSFERABLE.~~

The certificate is issued only to the agency named in the application, for the period specified, and for the location indicated in the application, and to the owners or operators as expressed on the application submitted to the Department. The certificate may not be transferred or assigned to any other person or entity. The certificate is nontransferable from one (1) location to another. (3-17-22)

~~117. RESTRICTION ON CERTIFICATION.~~

A business entity established by a parent for the sole purpose of providing DDA services to their own child cannot be certified as a DDA. (3-17-22)

118. ~~AVAILABILITY OF CERTIFICATE.~~

The certificate must be posted in a conspicuous location in the DDA where it may be seen readily by the participants and members of the public. (3-17-22)

1197. ~~AGENCIES ORGANIZATIONS APPROVED THROUGH NATIONAL ACCREDITATION.~~

~~Agencies approved by national accrediting bodies must maintain Department certification requirements in the following~~ Organizations that are accredited are required to produce the following records to renew a certificate: (3-17-22)()

01. The Current Accreditation Verification or Report. (3-17-22)
02. Criminal History Background Check Requirements. ~~See Section 009 of these rules;~~ (3-17-22)()
03. ~~Personnel~~ Staff Records. ~~See Subsection 301.04 of these rules;~~ (3-17-22)()
04. ~~General Training Requirements.~~ See Section 302 of these rules; and (3-17-22)
05. ~~Facility Standards for Agencies Providing Center-Based Services.~~ See Section 400 of these rules. (3-17-22)

120. ~~RENEWAL AND EXPIRATION OF THE CERTIFICATE.~~

~~01. Renewal Request.~~ An agency must request renewal of its certificate no less than ninety (90) days before the expiration date of the certificate, to ensure there is no lapse in certification. (3-17-22)

~~02. Expiration Without Timely Request for Renewal.~~ Expiration of a certificate without a timely request for renewal automatically rescinds the agency's certificate to deliver services under these rules. If an agency's certificate is rescinded, a new application for certification must be submitted to deliver services under these rules. (3-17-22)

12418. -- 299. (RESERVED)

GENERAL ~~AGENCY~~ ORGANIZATION QUALIFICATIONS AND REQUIREMENTS
Sections 300-399

300. GENERAL STAFFING REQUIREMENTS ~~FOR AGENCIES.~~

~~Each DDA is accountable for all operations, policy, procedures, and service elements of the agency~~ The organization must have a qualified administrator, supervisor and direct service provider (DSP) to meet the needs of participants served. The organization administrator and supervisor can be the same individual if the organization can meet requirements of each duty. (3-17-22)()

01. ~~Agency Administrator Qualifications~~ and Duties. The ~~agency~~ administrator must have two (2) years of supervisory experience with the population served ~~in an administrative role.~~ On a temporary basis, ~~An~~ administrator may ~~designate a qualified individual to perform~~ delegate administrative functions on their behalf. ~~The administrator or their designee is responsible for the overall operations of the organization, including compliance with these rules.~~ (3-17-22)()

02. ~~Agency Administrator Duties.~~ An agency administrator is accountable for the overall operations of the agency, including ensuring compliance with these rules, overseeing and managing personnel, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. (3-17-22)

03. ~~Supervisor Qualifications.~~ The agency must have documentation that ensures personnel acting in a supervisory capacity meets qualifications as required by the payer source for the service provided. The agency administrator and supervisor can be the same individual if the agency can meet requirements of each duty. (3-17-22)

042. Supervisor Duties. ~~Complete or obtain the plan of service, supervise DSP, including at least quarterly supervision, and coordinate other service providers to ensure continuity of service delivery.~~ (3-17-22)(____)

a. ~~Complete or obtain participant assessments and plans according to the authorized plan of service.~~ (3-17-22)

b. ~~Provide personnel initial direction, procedural guidance, and monthly supervision of work performed to ensure programs are implemented as written and demonstrate the necessary skills to provide the services.~~ (3-17-22)

05. Direct Service Provider (DSP) Qualifications. ~~A person qualified to provide services must meet the qualifications prescribed for the type of services to be rendered and training requirements of Section 302 of these rules.~~ (3-17-22)

063. DSP Duties. Perform tasks as assigned under the direction of a supervisor. Tasks may not be assigned that require specific certification or licensure. (3-17-22)

074. Parent or Legal Guardian of Participant. A DDA may not hire the parent or legal guardian of a participant to provide services to the parent's or legal guardian's child. (3-17-22)

08. Volunteer Workers in a DDA. ~~If volunteers are utilized, the agency must establish written policies and procedures governing the screening, training, and utilization of volunteer workers. If a volunteer is working directly with participants, they must meet the qualifications, training, and record requirements of a DSP.~~ (3-17-22)

301. AGENCY ORGANIZATION RECORD REQUIREMENTS.

01. Accessibility of Agency Records. ~~The agency~~ An organization's records ~~required under these rules must be accessible~~ available to the Department ~~during normal operations of the agency for the purpose of inspection and copying, with or without prior notification, under Section 39-4605(4), Idaho Code, with or without prior notification.~~ (3-17-22)(____)

02. General Record Requirements. ~~Each agency certified under these rules~~ The organization must maintain accurate, current, and complete ~~administrative, personnel, and participant~~ records for ~~at least a minimum of~~ five (5) years. (3-17-22)(____)

03. Administrative Records. ~~Records must include:~~ (3-17-22)

a. ~~An organizational chart;~~ (3-17-22)

b. ~~Legal authority identified in organizational bylaws or other documentation of legal authority of ownership; and~~ (3-17-22)

c. ~~Fiscal records verifying service delivery prior to request for payment.~~ (3-17-22)

043. Personnel Staff Records. ~~Records must include~~ contain the following: (3-17-22)(____)

a. ~~Name, current address, and phone number of the employee, date of hire and termination, if applicable;~~ (3-17-22)(____)

b. ~~Documentation supporting qualifications to carry out assigned duties;~~ (3-17-22)

c. ~~Verification of satisfactory completion of criminal history checks under IDAPA 16.05.06, "Criminal History and Background Checks."~~ (3-17-22)

d. ~~Date of Employment;~~ (3-17-22)

- ~~e.~~ Documentation of training under Section 302 of these rules; (3-17-22)
 - ~~f.~~ Evidence of current age-appropriate CPR and first aid certifications; (3-17-22)
 - ~~g.~~ Current assistance with medications certification, if applicable; (3-17-22)
 - ~~h.~~ Other current certifications, as applicable; (3-17-22)
 - ~~i.~~ Obtain and maintain documentation of licenses and certifications for drivers and vehicles under public transportation laws, regulations, and ordinances that apply to the agency to conduct business and to operate the types of vehicles used to transport participants Current driver's license and automobile liability insurance for staff who transport participants; (3-17-22)()
 - ~~j.~~ Continuously maintain liability insurance that covers all passengers and meets the minimum liability insurance requirements under Idaho law. The agency will ensure that liability insurance coverage is carried to cover circumstances when an employee transports participants in their personal vehicle; and (3-17-22)
 - ~~k.~~ Date and reason for termination, if applicable. (3-17-22)
- 054. Participant Records Requirements.** Each agency must have an organized participant records system to provide past and current information and to safeguard participant confidentiality under these rules that Records must contain the following: (3-17-22)()
- ~~a.~~ Clear documentation of the date, time, duration, and type of service with credentialed signature and corresponding initials of the individual providing the service, for each service provided. Documentation of type and duration of services delivered, including the date, time, and name of person providing the service; (3-17-22)()
 - ~~b.~~ Profile sheet containing the following information: (3-17-22)
 - ~~i.~~ Current living arrangement Name, address, phone number, and contact information of guardian (if applicable) or emergency contact; (3-17-22)()
 - ~~ii.~~ Complete address and contact information for the participant, guardian (if applicable), emergency contacts, and physician; (3-17-22)
 - ~~iii.~~ Current medications and allergies; and (3-17-22)
 - ~~iv.~~ Special General health information including specific dietary or medical needs, and health care providers; (3-17-22)()
 - ~~ed.~~ Signed Notification of participant rights, access to grievance procedures, and the names, addresses, and telephone numbers of contact information for protection and advocacy services that is clear and understandable; and; (3-17-22)()
 - ~~de.~~ Authorized plan of service for the participant; and incident reports. (3-17-22)()
 - ~~e.~~ Assessments from a health care professional, if relevant or needed for service provision due to medical or behavioral condition; (3-17-22)
 - ~~f.~~ An evaluation to be completed by a qualified supervisor or obtained by the agency, if applicable; (3-17-22)
 - ~~g.~~ Implementation plans, as applicable; (3-17-22)
 - ~~h.~~ Written documentation that identifies the participant's progress toward goals defined on their plan of service; and (3-17-22)

- i. Incident reports under Section 404 of these rules. (3-17-22)

302. GENERAL TRAINING REQUIREMENTS.

~~Each DDA must ensure that all training of staff is completed as follows~~The organization must document all staff training, including the date, description of training, and name of the person conducting the training. Staff must be trained on the following: (3-17-22)()

01. Initial and Annual Training. Prior to working with participants and annually thereafter, ~~direct service providers are to~~ staff must complete: (3-17-22)()

a. Safety training ~~to include location based structural and environmental risks, and on~~ natural disasters; (3-17-22)()

b. Abuse, neglect, and exploitation training covering definitions and reporting requirements; (3-17-22)

c. ~~Agency adopted ethical standards~~Organization's policy and procedures; (3-17-22)()

d. Participant's rights, advocacy resources, and confidentiality; and (3-17-22)

e. Behavior intervention strategies and techniques including appropriate responses to maladaptive behaviors; ()

ef. ~~For center-based services, fire training to include policies and procedures, fire drills, and emergency evacuation plans~~For DDA centers and Adult Residential Care Facility services, fire safety training, fire drills, and emergency evacuation plans. (3-17-22)()

02. CPR and First Aid Training. Staff must be certified in CPR and first aid prior to working alone with participants and ongoing thereafter. ()

023. Participant-Sufficient Specific Training. ~~Prior to delivering services, DSPs must be trained on the specific needs of the participant including medical, or health requirements, and the use of assistive devices if applicable;~~ (3-17-22)()

a. Prior to working alone with participants, DSPs will receive basic introductory review of participant information to provide services and supports, to include the following: (3-17-22)

i. Participant's profile sheet; (3-17-22)

ii. Correct and appropriate use of assistive technology used by participants; and (3-17-22)

iii. Special, medical, or health requirements. (3-17-22)

b. Supervisor will provide or ensure training provided by a designee on the following, as applicable: (3-17-22)

i. Instructional techniques including correct and consistent implementation of the participant's implementation plan or plan of service; (3-17-22)

ii. Managing behaviors including techniques and strategies for teaching adaptive behaviors; and (3-17-22)

iii. Accurate record keeping and data collection procedures; (3-17-22)

03. Certification Training. (3-17-22)

a. Prior to working alone with participants, personnel receive age-appropriate certification in CPR

~~and first aid, and maintain current certification thereafter; and~~ (3-17-22)

~~b. Personnel assisting with participant medications successfully complete the assistance with medications training course available through an Idaho college or university;~~ (3-17-22)

~~c. Personnel that implement physical restraints receive and maintain certification in a nationally recognized physical intervention strategy.~~ (3-17-22)

04. Ongoing Training. ~~The supervisor provides and ensures ongoing training of DSPs~~ **must be trained** when there are changes that impact services or supports including: (3-17-22)(☐)

a. Participant's plan of service and corresponding implementation plans, as applicable; and (3-17-22)

b. Participant's physical, medical, and behavioral status. (3-17-22)

303. -- ~~399~~**403.** (RESERVED)

**FACILITY, SAFETY, AND HEALTH STANDARDS
Sections 400-499**

400. FACILITY STANDARDS FOR AGENCIES PROVIDING CENTER-BASED SERVICES.
When an agency is providing center-based services they must meet the following: (3-17-22)

01. Accessibility. Agencies designated under these rules must be responsive to the needs of individuals receiving services and accessible to individuals with disabilities as defined in Section 504 of the federal Rehabilitation Act, the ADA, and the uniform federal accessibility standard. The DDA must submit a completed checklist to the Department with the application for certification to verify compliance with the ADA requirements. (3-17-22)

02. Environment. The facilities of the agency must be designed and equipped to meet the needs of each participant including factors such as sufficient space, equipment, lighting, and noise control. (3-17-22)

03. Fire and Safety Standards. Center-based locations must: (3-17-22)

a. Meet all local and state codes concerning fire and life safety that are applicable to a DDA through annual inspection by the local fire authority or Idaho State Fire Marshal's office as required by local, city, or county ordinances, documented with inspection results and corrective actions taken on violations cited; (3-17-22)

b. Provide suitable fences, guards, or railings to protect participants on the premises where natural or man-made hazards are present; (3-17-22)

c. Remove the accumulation of weeds, trash, and rubbish; (3-17-22)

d. Limit and use of portable heating devices that have heating elements to not more than two hundred twelve degrees Fahrenheit (212°F), certified by Underwriters Laboratories, and approved by the local fire or building authority; (3-17-22)

e. Properly label and store all hazardous or toxic substances under lock and key; (3-17-22)

f. Maintain water temperatures in areas accessed by participants at one hundred twenty degrees Fahrenheit (120°F) or below; and (3-17-22)

g. Have a telephone available on the premises with emergency numbers near the telephone for use in the event of an emergency. (3-17-22)

04. Evacuation Plans. Evacuation plans must be posted throughout the center and indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of the

building. (3-17-22)

05. Fire Drills. The DDA must conduct and document quarterly fire drills, and meet the following: (3-17-22)

and **a.** At least two (2) times each year these fire drills will include complete evacuation of the building; (3-17-22)

b. A brief summary of each fire drill conducted, written, and maintained on file indicating the date, time, and duration the drill occurred, participants and personnel participating, problems encountered, and corrective action(s) taken. (3-17-22)

06. Food Safety and Storage. (3-17-22)

a. When the agency provides food service for participants and meets the definition of a “food establishment,” in Section 39-1602, Idaho Code, the agency must comply with IDAPA 16.02.19, “Idaho Food Code.” Compliance is verified through inspection by the local District Health Department. (3-17-22)

b. Refrigerators and freezers used to store participant foods will be maintained at or below forty-one degrees Fahrenheit (41°F), and ten degrees Fahrenheit (10°F) respectively, and in good repair. (3-17-22)

c. When medicines requiring refrigeration are stored in a food refrigerator, medicines must be stored in a package and kept inside a covered, leak-proof container that is clearly identified as a container for the storage of medicines. (3-17-22)

07. Housekeeping and Maintenance Services. The agency must meet the following: (3-17-22)

a. Maintain the interior and exterior of the center be maintained in a clean, safe, and orderly manner and kept in good repair; (3-17-22)

b. Not use deodorizers to cover odors caused by poor housekeeping or unsanitary conditions; (3-17-22)

c. Ensure the agency is free from infestations of insects, rodents, and other pests; and (3-17-22)

d. Maintain the temperature and humidity of the agency within a normal comfort range by heating, air conditioning, or other means. (3-17-22)

401. SETTING REQUIREMENTS.
The service setting must meet the needs of the participant as follows: (3-17-22)

01. Accessibility. Be accessible, safe, and appropriate. (3-17-22)

02. Environment. Be assessed to meet the needs of each participant including factors such as sufficient space, equipment, lighting, and noise control. (3-17-22)

03. Promote Inclusion. Promote the participant’s inclusion in the natural setting. (3-17-22)

402. TRANSPORTATION POLICY.
Each agency must develop and implement transportation policies that include the following: (3-17-22)

01. Preventative Maintenance Program. Establish a preventive maintenance program for each agency-owned or leased vehicle, including vehicle inspections and other regular maintenance to ensure participant safety. (3-17-22)

02. Adequate Staffing. Ensure adequate staffing for participants who require additional supervision during transportation for the safety of all vehicle occupants. (3-17-22)

~~03. Licenses, Certifications, and Insurance for Drivers and Vehicles.~~ Ensure adequate insurance coverage to protect the individuals utilizing agency transportation. This may include commercial vehicle insurance and employee vehicle insurance coverage. Obtain and maintain licenses, certifications, and insurance for drivers and vehicles required by public transportation laws, regulations, and ordinances. (3-17-22)

~~04. Laws, Rules, and Regulations.~~ Adhere to all laws, rules, and regulations applicable to drivers and types of vehicles used. (3-17-22)

~~403. HEALTH POLICY.~~
Each DDA must develop and implement policies and procedures that: (3-17-22)

~~01. Ensure Personnel are Disease-Free.~~ Describe how the agency will ensure that personnel are free from communicable disease; (3-17-22)

~~02. Protect Participants.~~ Describe how the agency will protect participants from exposure to individuals exhibiting symptoms of illness. (3-17-22)

~~03. Medication Standards.~~ Implement medication requirements under Section 405 of these rules. (3-17-22)

~~04. Address Needs of Participants.~~ Address any special medical or health care needs of participants as relevant to service delivery. (3-17-22)

~~404. AGENCY ORGANIZATION REPORTING POLICY.~~
Each agency must develop and implement written policies and procedures outlining how the agency will document reporting and other communications for the following requirements: (3-17-22)

~~01. Incident Reports.~~ Document all participant incidents that occur during service delivery and affect the ability to participate in services. Each report will document that the participant's legal guardian has been notified within twenty-four (24) hours. A documented review by the agency of all incident reports will be completed at least annually with written recommendations and retained by the agency for five (5) years. (3-17-22)

~~021. Reporting Requirements.~~ Any agency employee, contractor, or volunteer will report all suspected incidents and allegations of mistreatment, abuse, neglect, or exploitation to the administrator, adult or child protection authorities, or law enforcement under The organization will follow Sections 39-5303 and 16-1605, Idaho Code when there are allegations of abuse, neglect, or exploitation. The agency organization will protect the participant from the possibility of abuse during services while the investigation is in progress. The administrator will ensure the events and the agency response to the events are documented in the participant record organization will document their investigation of all alleged violations. (3-17-22)()

~~032. Reporting Incidents to the Department.~~ ~~Through a Department-approved process, the agency administrator or designee~~ The organization must notify the Division of Licensing and Certification by the close of the next business day of ~~any significant~~ the following incidents that occur to the participant during service hours including: (3-17-22)()

- a. Death; (3-17-22)
- b. Hospitalization; (3-17-22)
- c. Participant's arrest or incarceration; or (3-17-22)
- d. When staff actions result in a report to protective or legal authorities. (3-17-22)

~~405. MEDICATION POLICY.~~
Each agency organization must ~~develop and implement written medication policies and procedures that outline in detail how the agency will~~ ensure appropriate handling and safeguarding of medications. ~~If the agency chooses to~~

~~assist participants with medications, the agency must also develop and implement specific policies and procedures to ensure assistance is safe and delivered by qualified, fully-trained personnel. Staff assisting participants with medications must complete the assistance with medications training course available through a Department-approved training.~~ (3-17-22)()

01. Handling of Participant's Medication. The ~~agency~~ organization must: (3-17-22)()

~~a. Maintain that the medication is in the original pharmacy-dispensed container, original over-the-counter container, or placed in a unit container (by a licensed nurse or pharmacy staff) appropriately labeled with the name of the medication, dosage, time to be taken, route of administration, and any special instructions. Each medication will be packaged separately, unless in a Mediset, blister pack, or similar system.~~ (3-17-22)()

~~b. Maintain evidence of the written or verbal order for the medication from the health care professional in the participant's record. Medisets~~ Medication and treatment must be provided per the health care professional's orders. DDA's and residential habilitation agencies may use Medi sets filled and labeled by a pharmacist pharmacy staff or licensed nurse can serve as written evidence of the order. An original prescription bottle labeled by a pharmacist describing the order and instructions for use can also serve as written evidence of an order from the health care professional; and (3-17-22)()

~~c. Be responsible to safeguard the participant's medications while the participant is at the agency or in the community.~~ (3-17-22)

~~d. The organization must store medications under the proper conditions and according to manufacturer's recommendations.~~ ()

~~e. Not retain medications that are no longer used by the participant for longer than~~ Discontinued or outdated medications must be removed from the participant's medication supply within thirty (30) calendar days. (3-17-22)()

02. Self-Administration of Medication. ~~Written approval is required when the participant is responsible for administering their own medication without assistance, stating the participant's health care professional has evaluated the participant's ability to self-administer medication, and has found that the participant. A participant can self-administer medication when there is written approval from a health care professional supporting the participant is capable of completing this task safely.~~ (3-17-22)()

~~a. Understands the purpose of the medication;~~ (3-17-22)

~~b. Knows the appropriate dosage and times to take the medication;~~ (3-17-22)

~~c. Understands expected effects, adverse reactions or side effects, and action to take in an emergency;~~ (3-17-22)
and

~~d. Is capable of taking the medication without assistance.~~ (3-17-22)

03. Assistance with Medication. ~~An agency may assist participants with medications; however, only a health care professional may administer medications. Prior to unlicensed agency personnel assisting participants with medication, Staff must follow policy and procedures for assisting participants with medications, and the following conditions must be in place:~~ (3-17-22)()

~~a. Personnel assisting with participant medications successfully complete the assistance with medications training course available through an Idaho college or university;~~ (3-17-22)

~~b.a. The participant's health condition is stable; and~~ (3-17-22)()

~~b.b. The participant's health status does not require nursing assessment before receiving the medication or nursing assessment of the therapeutic or side effects after the medication is taken;~~ (3-17-22)

04. Medication Record. Record must contain the following: ()

~~d.~~ The medication is in the original pharmacy-dispensed container with proper label and directions, in an original over-the-counter container, or the medication has been placed in a unit container by a licensed nurse. Proper measuring devices will be available for liquid medication that is poured from a pharmacy-dispensed container; (3-17-22)

~~e.~~ Written and oral instructions from a physician, practitioner of the healing arts, health care professional, pharmacist, or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions, side effects, and action to take in an emergency have been reviewed; (3-17-22)

~~f.~~ Written instructions are in place that outline required documentation of assistance including the following: (3-17-22)

~~ia.~~ Name of the participant; (3-17-22)

~~ib.~~ Name and dosage of the medication given; (3-17-22)

~~ic.~~ Time and date the medication was given; (3-17-22)

~~id.~~ Initials of individual assisting with medication that can be verified with matching signature; (3-17-22)

~~ve.~~ Documentation of medication errors ~~to, include~~ ing any missed doses, not taken, incorrect medication taken, doses, overdose occurrence, or side effects observed or adverse side effects; (3-17-22)()

~~vi.~~ Health care professional contacted to determine the level of threat to the individual's health and determine the treatment required, if any; and Documentation that a health care professional was contacted for adverse events; and (3-17-22)()

~~vii.~~ Documentation of corrective action ~~taken and results~~ for adverse events or incidents of repeated medication errors. (3-17-22)()

~~g05.~~ **Disposal of Medications.** Procedures for Documentation of disposal or destruction of medications ~~must be documented and~~ consistent with procedures outlined in the assistance with medication training course. (3-17-22)()

406. GRIEVANCE POLICY.

~~Each DDA must develop and implement written grievance policies and procedures that outline in detail the agency's grievance policy. The policy must include how the agency will ensure participant and guardian are aware of the process, how to file a grievance, and receive a response from the agency in fourteen (14) days or less. (3-17-22)~~

~~407~~6. – 499. (RESERVED)

**QUALITY ASSURANCE, ~~PARTICIPANT RIGHTS, REQUIRED POLICIES, ETC~~ BEHAVIOR
MANAGEMENT, AND SPECIFIC PROGRAM REQUIREMENTS.**

Sections 500-599

500. REQUIREMENTS FOR AN ~~AGENCY'S~~ ORGANIZATION'S QUALITY ASSURANCE PROGRAM.

~~Each agency organization must develop and implement a quality assurance program that improves the quality of services, identifies any corrections needed, a time frame for those corrections, and ensures the following: non-compliance or safety issues including corrective measures and timeframes. This review must include; (3-17-22)()~~

01. Measurable Outcomes. Produces high quality services that maintain interests, needs, and current standards of practice consistent with individual choices. This includes: (3-17-22)

~~a01. Review of pParticipant rRecords.~~ for content and effectiveness of programs; and Assess for accurate content and effectiveness of service delivery; (3-17-22)()

~~b. A method for gathering and assessing participant satisfaction;~~ (3-17-22)

~~02. Available Personnel and Resources~~**Staff Records.** Sufficient personnel and material resources are available to meet the needs of each individual served to include a review of: Assess that staff have the necessary skills and training to provide adequate service delivery; and (3-17-22)()

~~a. Personnel records for content.~~ (3-17-22)

~~b. Supervision and training data to ensure there are personnel who have the skills necessary to provide the service.~~ (3-17-22)

~~c. Work scheduled to assure coverage.~~ (3-17-22)

~~03. Health and Safety Supports.~~ The overall agency practices are within rule and support participant health and safety to include a review of: (3-17-22)

~~a. Code of ethics, identification of violations, and implementation of an internal plan of correction;~~ (3-17-22)

~~b03. Policyies and pProcedures.~~ manual to specify date and content of revisions made; Review to ensure content meets the needs of participants served. (3-17-22)()

~~c. Center-based facilities, if applicable, to ensure compliance with these rules.~~ (3-17-22)

501. --~~504.~~ **(RESERVED)**

505. PARTICIPANT RIGHTS.

Each agency must ensure the rights provided under Section 66-412, Idaho Code, as well as the additional rights listed below for each participant receiving DDA services. (3-17-22)

~~01. Participant Rights Provided Under Idaho Code.~~ Provide the following rights for participants: (3-17-22)

~~a. Humane care and treatment;~~ (3-17-22)

~~b. Not be put in isolation;~~ (3-17-22)

~~c. Be free of restraints, unless necessary for the safety of that individual or for the safety of others;~~ (3-17-22)

~~d. Be free of mental and physical abuse;~~ (3-17-22)

~~e. Voice grievances and recommend changes in policies or services being offered;~~ (3-17-22)

~~f. Practice their own religion;~~ (3-17-22)

~~g. Wear their own clothing and retain and use personal possessions;~~ (3-17-22)

~~h. Be informed of their medical and habilitative condition, of services available at the agency, and the charges for the services;~~ (3-17-22)

~~i. Reasonable access to all records concerning themselves;~~ (3-17-22)

- ~~j.~~ Refuse services; (3-17-22)
- ~~k.~~ Exercise all civil and all other rights established by law, unless limited by prior court order; (3-17-22)
- ~~l.~~ Privacy and confidentiality; (3-17-22)
- ~~m.~~ Receive a response from the agency to any request made within fourteen (14) business days; (3-17-22)
- ~~n.~~ Receive services that enhance the participant's social image, personal competencies, and whenever possible, promote inclusion in the community; (3-17-22)
- ~~o.~~ Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law; and (3-17-22)
- ~~p.~~ Review the results of the most recent survey conducted by the Department and the accompanying plan of correction. (3-17-22)

~~02.~~ **Method of Informing Participants of Their Rights.** Each agency must ensure and document that each participant receiving services is informed of their rights in the following manner: (3-17-22)

- ~~a.~~ Upon initiation of services, provide each participant and their parent or guardian, where applicable, with a packet of information that outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet must be written in easily understood terms. (3-17-22)
- ~~b.~~ When providing center-based services, prominently post a list of the rights contained in this chapter. (3-17-22)
- ~~c.~~ Provide each participant and their parent or guardian, where applicable, with a verbal explanation of their rights in a manner that will best promote individual understanding of these rights. (3-17-22)

~~506.~~ 509. (RESERVED)

~~510.~~ **~~POLICIES AND PROCEDURES REGARDING DEVELOPMENT OF RESTRICTIVE INTERVENTIONS~~MANAGING PARTICIPANT BEHAVIOR.**

Each agency must develop and implement written policies and procedures that address restrictive interventions to include the following:The use of systematic interventions to manage inappropriate or maladaptive participant behaviors must follow facility policy and be incorporated into the participant's individual service plan. (3-17-22)()

~~01.~~ **~~Protected Rights~~**. Ensure the safety, welfare, and human and civil rights of participants are adequately protected. (3-17-22)

~~021.~~ **~~Appropriate Use of Interventions~~Techniques to Manage Maladaptive Behavior.** Ensure interventions used to manage participants' maladaptive behavior are never Interventions to manage behaviors must never be used: (3-17-22)()

- ~~a.~~ For disciplinary purposes; (3-17-22)
- ~~b.~~ For the convenience of personnel or lack of staff; or (3-17-22)()
- ~~c.~~ As a substitute for a needed training an active treatment program; or or needed training. (3-17-22)()
- ~~d.~~ By untrained or unqualified personnel. (3-17-22)

~~032. Use of Restraint on Participants~~Physical Restraints and Time Out Requirements. No restraints, other than physical restraint in an emergency, must be used on participants prior to the use of positive behavior interventions. The following requirements apply to the use of physical restraint on participants by qualified personnel: Physical restraints and time out must be: (3-17-22)()

a. ~~Physical restraint may be used in an isolated emergency to prevent injury to the participant or others and must be documented and reviewed by the DSP and the supervisor. Documentation must include a debrief with the participant, guardian, and DSP involved focusing on strategies to avoid the occurrence of future physical restraints.~~Used as an emergency measure when other lesser restrictive interventions have failed and there is substantial risk for harm to self or others; or (3-17-22)()

b. ~~Physical restraint may be used in a non-emergency setting when a written behavior program is developed by a supervisor, the participant, and their guardian, if applicable, and approved by a health care professional. Informed consent is required by the participant and parent or legal guardian.~~Part of an integral service plan that is intended to lead to less restrictive means of managing or eliminating the behavior for which the restraint is applied. (3-17-22)()

c. Utilized by staff that have been certified in a nationally recognized behavior management program approved by the Department. ()

d. Used only until the participant has regained control. ()

e. Documented in the participant record including date, time, duration, staff involved and description of behaviors. ()

~~043. Written Informed Consent. If the program contains restrictive or aversive components, an individual working within the scope of their license or certification must also review and approve, in writing, the plan prior to implementation. The participant, parent or legal guardian, if applicable, must also consent prior to implementation. When programs implemented by the agency are developed by another service provider, the agency must obtain a copy of these reviews and approvals. If an organization uses physical restraints as part of their behavior management program, participants, and their legal guardian, if applicable, must provide written informed consent.~~ (3-17-22)()

511. STANDARDS FOR A DDA CENTER AND ADULT RESIDENTIAL CARE FACILITY.

01. Environment. The facility must be designed and equipped to meet the needs of each participant including sufficient space, adaptive equipment, lighting, and noise control. Facilities providing residential care must provide participants with sleeping rooms including furnishings, such as a dresser and bed, and be safe and in good repair. ()

02. Construction Changes. For changes of occupancy, modifications, additions, or renovations to existing buildings, the facility must submit certificate of occupancy to the Department for approval prior to admitting participants. ()

03. Fire Safety Standards. Locations must maintain the following records: ()

a. A copy of an annual local fire authority inspection including any necessary corrective actions; ()

b. Documentation of quarterly fire drills, including date, time, duration, names of participants and staff involved, and any resulting corrective action(s); and ()

c. Documentation that at least two (2) times each year fire drills included a complete evacuation of the building. ()

04. Environment Safety Standards. ()

a. Provide fences, guards, or railings to protect participants on the premises where natural or man-made hazards are present; ()

b. Portable heating devices must be approved by the local fire authority; ()

c. Properly label and store all hazardous or toxic substances under lock and key; ()

d. Maintain water temperatures in areas accessed by participants at one hundred twenty degrees Fahrenheit (120°F) or below; ()

e. Have a telephone on the premises with emergency numbers available; and ()

f. Evacuation plans must be posted throughout the center and indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of the building. ()

05. Food Safety and Nutrition. ()

a. Adult residential care facilities must: ()

i. Meet the standards in IDAPA 16.02.19. Compliance is verified through inspection by the local District Health Department. ()

ii. Provide three (3) daily balanced meals in appropriate intervals. ()

iii. Menu must be planned, approved, signed and dated by a registered dietician. Menus must be maintained on file for sixty (60) days and include any substitutions. ()

iv. Accommodations must be made to a participant with special medical or religious dietary needs. ()

b. Refrigerators and freezers used to store participant foods will be maintained at or below forty-one degrees Fahrenheit (41°F), and ten degrees Fahrenheit (10°F) respectively; and ()

c. When medicines requiring refrigeration are stored in a food refrigerator, medicines must be stored in a package and kept inside a covered, leak-proof container that is identified as a container for the storage of medicines. ()

06. Housekeeping and Maintenance Services. The organization must meet the following: ()

a. The center must be clean, safe, and kept in good repair; ()

b. Ensure the building is free from infestations of insects, rodents, and other pests; and ()

c. Maintain the temperature and humidity of the building within a normal comfort range by heating, air conditioning, or other means. ()

512. RESIDENTIAL HABILITATION AGENCIES TERMINATION PROCEDURES.

01. Emergency Termination. Emergency conditions warranting immediate termination of services include: ()

a. A change in the participant's condition resulting in an increased level of care beyond the scope of the organization's ability to provide care for the participant; or ()

b. Significant behavior concerns including physical aggression by the participant that puts the health and safety of the organization's staff or other participants in jeopardy and behavior management techniques have

failed to reduce the risk to staff or others. ()

02. Termination with Notice. The organization must provide written notice of no less than thirty (30) days for termination, include a transition plan, and a copy of the organization grievance policy. A transition plan is an interim plan defining activities to facilitate the transition out of residential habilitation services. ()

03. Termination with Agreement. Services may be terminated prior to thirty (30) days if both parties agree in writing. ()

5143. -- 599. (RESERVED)

RULE ENFORCEMENT PROCESS AND REMEDIES SECTIONS 600-699

600. ENFORCEMENT PROCESS.

The Department may impose a remedy an enforcement action when it determines an agency has not met the requirements in these rules organization is not in compliance with these rules. The Department may monitor the organization on an as-needed basis, until it has been established the organization is in substantial compliance. (3-17-22)()

01. Determination of Remedy. In determining which remedy to impose, the Department will consider the agency's organization's compliance history, change of ownership, the number of deficiencies, the scope and severity of the deficiencies, and the potential risk to participants. Subject to these considerations, any one or combination of the following remedies, is subject under these rules for notice and appeal: (3-17-22)()

a. Require the agency organization to submit a plan of correction approved in writing by the Department; (3-17-22)()

b. Issue a provisional certificate with a specific date for correcting deficient practices; (3-17-22)()

~~c.~~ Ban enrollment of all participants with specified diagnoses; (3-17-22)

~~d.~~ Ban any new enrollment of participants; (3-17-22)()

~~e.~~ Summarily suspend the certificate and transfer participants; or (3-17-22)

~~f.~~ Revoke the agency's organization's certificate. (3-17-22)()

02. Immediate Jeopardy. If the Department finds it is determined an agency's deficiency organization's non-compliance with these rules immediately jeopardizes the health or safety of its a participants, the Department may certificate may be summarily suspend the agency's certificateed. (3-17-22)()

03. Repeat Deficiency. If the Department finds a repeat deficiency in an agency, it may impose any of the remedies listed in Subsection 600.01 of this rule, The Department may monitor the agency on an as-needed basis, until the agency has demonstrated to the Department's satisfaction that it is in compliance with these rules. If so, then certification will be granted. If not, the certificate will be denied or revoked A Repeat deficiency may result in any of the remedies listed in this section. (3-17-22)()

04. Failure to Comply. The Department may impose one (1) or more of the remedies specified in Subsection 600.01 of this rule if this section: (3-17-22)

~~a.~~ The if the agency organization has not complied with any requirement in these rules returned to compliance within three (3) months after the date it was notified of its failure to comply with such requirement; or of implementing a plan of correction. (3-17-22)()

~~b.~~ The agency has failed to correct the deficiencies stated in the agency's accepted plan of correction and as verified by the Department, via resurveys. (3-17-22)

601. REVOCATION OF CERTIFICATE.

01. **Revocation of the ~~Agency's Organizations~~ Certificate.** The Department may revoke a ~~agency's~~ certificate when ~~persuaded by the preponderance of the evidence that the agency organization~~ is not in substantial compliance with the requirements ~~in these rules. The certificate is the property of the state and must be returned to the state if it is revoked or suspended.~~ (3-17-22)()

02. **Causes for Revocation of the Certificate.** The Department may revoke any ~~agency's organization's~~ certificate for any of the following causes: (3-17-22)()

a. The certificate holder has willfully misrepresented or omitted information on the application for certification or other documents pertinent to obtaining a certificate; (3-17-22)

b. Conditions exist in the ~~agency organization~~ that endanger the health or safety of any participant; (3-17-22)()

c. Any act adversely affecting the welfare of participants is being permitted, performed, or aided and abetted by the person(s) supervising the provision of services in the ~~agency organization~~. Such acts include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; (3-17-22)()

~~d. The provider has demonstrated or exhibited a lack of sound judgment that jeopardizes the health, safety, or well-being of participants;~~ (3-17-22)

~~ed.~~ The ~~agency organization~~ has failed to comply with any of the conditions of a provisional certificate; (3-17-22)()

~~f. The agency has one (1) or more major deficiencies. A major deficiency is a deficiency that endangers the health, safety, or welfare of any participant;~~ (3-17-22)

~~g. An accumulation of minor deficiencies that, when considered as a whole, indicate the agency is not in substantial compliance with these rules;~~ (3-17-22)

~~h. Repeat deficiencies by the agency of any requirement of these rules or of the Idaho Code;~~ (3-17-22)

~~ic.~~ The ~~agency organization~~ lacks adequate ~~personnel staff~~, as required by these rules or as directed by the Department, to properly care for the number and type of participants served at the ~~agency organization; or~~ (3-17-22)()

~~j. The agency is not in substantial compliance with the provisions for services required in these rules or with the participants' rights under Section 505 of these rules;~~ (3-17-22)

~~kf.~~ The certificate holder refuses to allow the Department or protection and advocacy agencies full access to the ~~agency organization~~ environment, ~~agency organization~~ records, or the participants. (3-17-22)()

602. **NOTICE OF ENFORCEMENT REMEDY:**

The Department will notify the following of the imposition of any enforcement remedy on a agency: (3-17-22)

01. **Notice to Agency.** The Department will notify the agency in writing, transmitted in a manner that will reasonably ensure timely receipt. (3-17-22)

02. **Notice to Public.** The Department will notify the public by sending the agency printed notices to post. The agency must post all the notices on the premises of the agency in plain sight in public areas where they will readily be seen by participants and their representatives, including exits and common areas and with the notices remaining in place until all enforcement remedies have been officially removed by the Department. (3-17-22)

602. INJUNCTION TO PREVENT OPERATION WITHOUT CERTIFICATE.

Notwithstanding the existence or pursuit of any other remedy, the Department may in the manner provided by law, maintain an action in the name of the state for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management, or operation of an organization without a certificate required under this chapter. For the purposes of these rules, a governmental unit is the state, or any county, municipality, or other political subdivision, or any department, division, board, or other organization thereof. ()

603. WAIVERS.

Waivers to these rules may be granted through the Department-approved process under Section 67-5230, Idaho Code. ()

6034. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.22 – RESIDENTIAL ASSISTED LIVING FACILITIES

DOCKET NO. 16-0322-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 39-3305 and 39-3358, 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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

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 4th, 2025, Idaho Administrative Bulletin, [Vol. 25-6, pages 126 through 174](#).

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.

DATED this 8th day of July, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 39-3305 and 39-3358, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Monday, June 9, 2025 1:00 PM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=mfa92068288da5b29e04435961568c15d Join by meeting number Meeting number (access code): 2829 726 2075 Meeting password: wqHuAZ3Su55 Meeting password when dialing from a phone or video system: 97482937 Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)
Friday, June 20, 2025 9:30 AM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m2f4078949547e149eb63e486e59c8c76 Join by meeting number Meeting number (access code): 2824 243 4131 Meeting password: dHMPGuh7i22 Meeting password when dialing from a phone or video system: 34674847 Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)

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:

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

SB 1102 passed by the 2025 Idaho Legislature revoked certain provisions contained in IDAPA 16.03.22, declaring them null, void, and of no force and effect. This ZBR Chapter Rewrite reflects amendments to codified text as it will look on July, 1, 2025, when the enacted legislation will become law, and not the rule chapter as it is currently enforceable. To view the official text of IDAPA 16.03.22 as it is currently effective, click [here](#).

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 25](#) and 26.

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 Jared Larsen at DHWRules@dhw.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 June 25th, 2025.

DATED this 2nd day of May, 2025.

Italicized red text that is double underscored indicates amendments to the proposed text as adopted in the pending rule.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0322-2501

16.03.22 – RESIDENTIAL ASSISTED LIVING FACILITIES

000. LEGAL AUTHORITY.

The Idaho Board of Health and Welfare is authorized under Sections 39-3305 and 39-3358, Idaho Code, to adopt and enforce rules to protect the health, safety, and individual rights for residents in residential assisted living facilities. (3-15-22)

001. ~~TITLE, SCOPE, AND RESPONSIBILITIES.~~

01. ~~Title.~~ The title of this chapter of rules is IDAPA 16.03.22, “Residential Assisted Living Facilities.” (3-15-22)

~~02. Scope.~~ The purpose of a residential assisted living facility is to provide choice, dignity, and independence to residents while maintaining a safe, humane, and home-like living arrangement for individuals needing assistance with daily activities and personal care. These rules set standards for providing services that maintain a safe and healthy environment for residential assisted living facilities. (3-15-22)()

~~03. General Provider Responsibilities.~~ The facility must ensure quality services by providing choices, dignity, and independence to residents. The facility must have an administrator and staff who have the knowledge and experience required to provide safe and appropriate services to all residents of the facility. The facility must be operated consistent with the rules and statutes as it conducts its work. (3-15-22)

~~04. General Department Responsibilities.~~ The Department is responsible for monitoring and enforcing the provisions of the statute and this chapter to protect residents in these facilities by providing information, education, and evaluating providers to ensure compliance with statute and these rules. This responsibility includes licensing facilities and monitoring the condition of facilities. (3-15-22)

002. WRITTEN INTERPRETATIONS.

This agency has written statements which pertain to the interpretations of the rules of this chapter or to the documentation of compliance with the rules of this chapter. These documents are available for public inspection on the program website <http://assistedliving.dhw.idaho.gov>. (3-15-22)

003. ADMINISTRATIVE APPEALS AND CONTESTED CASES.

Administrative appeals and contested cases are governed by IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-15-22)

004. INCORPORATION BY REFERENCE.

The documents referenced in this rule, are incorporated by reference as provided by Section 67-5229(a), Idaho Code. These incorporated documents are available for public review upon request at the Department of Health and Welfare, 450 West State Street, Boise, Idaho 83702, or when available online at the websites provided in these rules. (3-15-22)

~~01. National Fire Protection Association (NFPA) Documents.~~ (3-15-22)

~~a. National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, 2018 Edition, the occupancy chapters and all mandatory referenced documents contained therein under "Mandatory References."~~ (3-15-22)

~~b. National Fire Protection Association (NFPA) Standard 99, Health Care Facilities Code, 2018 Edition.~~ (3-15-22)

~~02. Idaho Diet Manual.~~ The manual is available from the Idaho Academy of Nutrition & Dietetics, Eleventh Edition, 2015, online at <http://eatrightidaho.org>. (3-15-22)

~~03. Idaho Food Code.~~ IDAPA 16.02.19, "Idaho Food Code." These rules are available online at <http://adminrules.idaho.gov/rules/current/16/160219.pdf>. (3-15-22)

~~04. Americans with Disabilities Act Accessibility Guidelines.~~ 28 CFR Part 36, Appendix A. This code is available online at <http://www.ada.gov/1991standards/adastd94-archive.pdf>. (3-15-22)

~~05. Idaho Board of Nursing Rules.~~ IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." These rules are available online at <https://adminrules.idaho.gov/rules/current/24/243401.pdf>. (3-15-22)

~~06. International Building Code.~~ IDAPA 24.39.30, "Rules of Building Safety." These rules are available online at <https://adminrules.idaho.gov/rules/current/24/243930.pdf>. (3-15-22)

~~0052.~~ -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Criminal History and Background Check. A residential assisted living facility must complete a criminal history and background check on employees and contractors ~~hired or contracted with after October 1, 2005,~~ who have direct resident access to residents in the residential assisted living facility. The Department check conducted under IDAPA 16.05.06, "Criminal History and Background Checks," satisfies this requirement. ~~Other criminal history and background checks may be acceptable provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee.~~ (3-15-22)()

02. ~~Scope of a Criminal History and Background Check.~~ ~~The criminal history and background check must, at a minimum, be fingerprint-based and include a search of the following record sources:~~ (3-15-22)

- ~~a. Federal Bureau of Investigation (FBI);~~ (3-15-22)
- ~~b. Idaho State Police Bureau of Criminal Identification;~~ (3-15-22)
- ~~c. Sexual Offender Registry;~~ (3-15-22)
- ~~d. Office of Inspector General List of Excluded Individuals and Entities; and~~ (3-15-22)
- ~~e. Nurse Aide Registry.~~ (3-15-22)

03. ~~Availability to Work.~~ ~~Any direct resident access individual hired or contracted with on or after October 1, 2005, must self-disclose all arrests and convictions before having access to residents.~~ (3-15-22)

a. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual must not have direct resident access to any resident. (3-15-22)

b. The individual is only allowed to work under another employee who has a cleared criminal history and background check ~~that meets the criteria in this rule. The cleared employee must keep the individual waiting for clearance in line-of-sight when the individual has direct resident access until the criminal history and background check is completed and the results are obtained by the facility, unless: while waiting for results. The unlicensed employee may not have one-to-one contact with a resident or access their personal belongings without the supervision of a cleared employee.~~ (3-15-22)()

i. ~~The individual has completed an alternative criminal history and background check that includes a search of the record sources listed in Subsection 009.02 except for Subsection 009.02.a. in this rule;~~ (3-15-22)

ii. ~~The facility determines there is no potential danger to residents; and~~ (3-15-22)

iii. ~~This alternative criminal history and background check is only in effect until the required criminal history and background check that meets the criteria in this rule is completed. The results must state whether the individual was cleared or denied based on the completed fingerprint-based background check.~~ (3-15-22)

04. ~~Submission of Fingerprints.~~ ~~The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of their date of hire.~~ (3-15-22)

05. ~~New Criminal History and Background Check.~~ ~~An individual must have a criminal history and background check when:~~ (3-15-22)

a. ~~Accepting employment with a new employer; and~~ (3-15-22)

b. ~~The individual's last criminal history and background check was completed more than three (3) years prior to their date of hire.~~ (3-15-22)

06. ~~Use of Previous Criminal History and Background Check.~~ ~~Any employer is allowed to use a previous criminal history and background check that meets the criteria in this rule if:~~ (3-15-22)

- a.** The individual has received a criminal history and background check within three (3) years of their date of hire; (3-15-22)
- b.** Prior to the individual being granted unsupervised direct resident access, the employer obtains and retains the individual's previous criminal history and background check results; (3-15-22)
- c.** The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, within thirty (30) days of obtaining the previous criminal history and background check results; and (3-15-22)
- d.** No disqualifying crimes are found. (3-15-22)
- 07.** **Employer Discretion.** The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within three (3) years of their date of hire. (3-15-22)

010. DEFINITIONS AND ABBREVIATIONS ~~A THROUGH E.~~

- 01.** **Abuse.** A non-accidental act of sexual, physical, or mental mistreatment or injury of a resident through the action or inaction of another individual. (3-15-22)
- 02.** **Accident.** An unexpected, unintended event that can cause a resident injury. (3-15-22)
- 03.** **Activities.** All organized and directed social and rehabilitative services a facility provides, arranges, or cooperates with. (3-15-22)
- 04.** **Activities of Daily Living.** Self-care actions necessary to sustain an individual in daily living, including bathing, dressing, toileting, grooming, eating, communicating, and managing medications. (3-15-22)
- 05.** **Administrator.** An individual licensed by the Idaho Bureau of Occupational Licenses as a Residential Assisted Living Facility Administrator. (3-15-22)
- 06.** **Administrator's Designee.** A person authorized in writing to act in the absence of the administrator who is knowledgeable of facility operations, the residents and their needs, emergency procedures, the location and operation of emergency equipment, and how the administrator can be reached in the event of an emergency. (3-15-22)
- 07.** **Adult.** A person who has reached eighteen (18) years of age. (3-15-22)
- 081.** **Advance Directive.** A written instruction, such as a living will or durable power of attorney for health care, recognized under state law, whether statutory or as recognized by the courts of the State, related to the provision of medical care when the individual is unable to communicate. (3-15-22)
- 09.** **Advocate.** An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of a population group served by a facility. (3-15-22)
- 10.** **Ambulatory Person.** A person who, unaided by any other person, is physically and mentally capable of walking a normal path to safety, including the ascent and descent of stairs. (3-15-22)
- 11.** **Assessment.** Information gathered that identifies resident strengths, weaknesses, risks, and needs, to include functional, social, medical, and behavioral needs. (3-15-22)
- 12.** **Authentication.** The process or action of proving or showing authorship to be true, genuine, or valid. (3-15-22)
- 13.** **Authorized Provider.** An individual who is a nurse practitioner, clinical nurse specialist, or

~~physician assistant.~~

(3-15-22)

~~1402. Behavior Plan. A written plan that decreases the frequency, duration, or intensity of maladaptive behaviors, and increases the frequency of adaptive behaviors~~ person-centered document outlining strategies to address and modify a specific behavior, developed based on a functional assessment that identifies the underlying cause of the behavior, and includes proactive steps to prevent the behavior, teach alternate appropriate behaviors, and provide reinforcement for positive interactions.

(3-15-22)()

~~1503. Call System. A signaling system whereby a resident can contact staff directly from their sleeping room, toilet room, and bathing area. The system may be voice communication, or an audible or visual signal, and may include wireless technology.~~ The call system cannot be configured in such a way as to breach a resident's right to privacy at the facility, including in the resident's living quarters, in common areas, during medical treatments, while receiving other services, in written and telephonic communications, or in visits with family, friends, advocates, and resident groups.

(3-15-22)()

~~16. Chemical Restraint. A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition.~~

(3-15-22)

~~1704. Cognitive Impairment. When a person experiences loss of short or long-term memory, orientation to person, place, or time, safety awareness, or loses the ability to make decisions that affect everyday life.~~

(3-15-22)

~~18. Complaint. A formal expression of dissatisfaction, discontent, or unhappiness by, or on behalf of, a resident concerning the care or conditions at the facility. This expression could be oral, in writing, or by alternative means of communication.~~

(3-15-22)

~~1905. Complaint Investigation. A survey to investigate the validity of allegations of noncompliance with applicable state requirements. Allegations will be investigated by the Licensing Agency as described in Section 39-3355, Idaho Code.~~

(3-15-22)

~~20. Core Issue. A core issue is any one (1) of the following:~~

(3-15-22)

~~a. Abuse;~~

(3-15-22)

~~b. Neglect;~~

(3-15-22)

~~c. Exploitation;~~

(3-15-22)

~~d. Inadequate care;~~

(3-15-22)

~~e. A situation in which the facility has operated for more than thirty (30) days without a licensed administrator overseeing the day-to-day operations of the facility;~~

(3-15-22)

~~f. Inoperable fire detection or extinguishing systems with no fire watch in place pending the correction of the system; or~~

(3-15-22)

~~g. Surveyors denied access to records, residents, or facilities.~~

(3-15-22)

~~2106. Criminal Offense. Any crime as defined in Section 18-111, Idaho Code, 18 U.S.C. Section 4B1.2(a), and 18 U.S.C. Sections 1001 through 1027.~~

(3-15-22)

~~22. Deficiency. A determination of noncompliance with a specific rule or part of a rule.~~

(3-15-22)

~~2307. Dementia. A chronic deterioration of intellectual function and other cognitive skills severe enough to interfere with the ability to perform activities of daily living.~~

(3-15-22)

~~24. Department. The Idaho Department of Health and Welfare.~~

(3-15-22)

2508. Developmental Disability. A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before twenty-two (22) years of age ~~and:~~ (3-15-22)()

~~a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism, or other conditions found to be closely related or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; (3-15-22)~~

~~b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, or economic self-sufficiency; and (3-15-22)~~

~~c. Reflects the need for a combination and sequence of special, interdisciplinary or direct care, treatment, or other services which are of life-long or extended duration, and individually planned and coordinated. (3-15-22)~~

2609. Direct Resident Access. In-person access with any resident who resides at the facility, or any access to the residents' personal belongings or information. (3-15-22)

~~27. Director. The Director of the Idaho Department of Health and Welfare or their designee. (3-15-22)~~

~~28. Electronic Signature. The system for signing electronic documents by entering a unique code or password that verifies the identity of the person signing and creates an individual "signature" on the record. (3-15-22)~~

2910. Elopement. When a resident who is cognitively, physically, mentally, emotionally, or chemically impaired, physically leaves the facility ~~premises~~ **property** or the secured unit or yard without personnel's knowledge. (3-15-22)()

~~30. Exit Conference. A meeting with the facility administrator or designee to: (1) provide review, discussion, and written documentation of non-core issues, and (2) to provide preliminary findings of core issues. (3-15-22)~~

~~31. Exploitation. The misuse of a resident's funds, property, resources, identity, or person for profit or advantage. This includes charging a resident for services or supplies not provided or disclosed in the written admission agreement and staff accepting gifts or money for extra services. (3-15-22)~~

041. DEFINITIONS AND ABBREVIATIONS F THROUGH N.

~~01. Follow-Up Survey. A survey conducted to confirm that the facility is in compliance and has the ability to remain in compliance. (3-15-22)~~

~~02. Governmental Unit. The state, any county, any city, or any department, division, board, or other agency. (3-15-22)~~

0311. Hourly Adult Care. Nonresident daily services and supervision provided by a facility to individuals who are in need of supervision outside of their personal residence(s) for a portion of the day. (3-15-22)

04. Immediate Danger. Any resident is subject to an imminent or substantial danger. (3-15-22)

~~05. Inadequate Care. When a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement, or provide for room, board, activities of daily living, supervision, first aid, assistance and monitoring of medications, emergency intervention, coordination of outside services, a safe living environment, engages in violations of resident rights, or takes residents who have been admitted in violation of the provisions of Section 152 of these rules. (3-15-22)~~

0612. Incident. An event that can cause a resident injury. (3-15-22)

~~07. Independent Mobility.~~ A person's ability to move about freely of their own choice with or without the assistance of a mobility device such as a wheelchair, cane, crutches, or walker. (3-15-22)

~~0813. Legal Guardian or Conservator.~~ A court-appointed individual designated to manage the affairs or finances of another person who has been found to be incapable of handling their own affairs. (3-15-22)

~~09. License.~~ A permit to operate a residential assisted living facility. (3-15-22)

~~10. Licensing Agency.~~ The Residential Assisted Living Facilities Program, a unit of the Division of Licensing and Certification within the Department of Health and Welfare, that conducts inspections and surveys of residential assisted living facilities and issues licenses based on compliance with this chapter of rules, in which "Residential Assisted Living Facilities Program" and "Licensing Agency" are synonymous. (3-15-22)

~~114. Maladaptive Behavior.~~ Any behavior that ~~interferes with resident care~~, infringes on any resident's rights, or presents a danger to the resident or others. ~~Involuntary muscle movements are not considered maladaptive behaviors.~~ (3-15-22)()

~~125. Medication.~~ Any substance used to treat a disease, condition, or symptom, which may be taken orally, injected, or used externally, and is available through prescription or over-the-counter. (3-15-22)

~~136. Medication Administration.~~ The process where a prescribed medication is given by a licensed nurse to a resident ~~through one (1) of several routes.~~ (3-15-22)()

~~147. Medication Assistance.~~ The process whereby a non-licensed care provider is delegated tasks by a licensed nurse, to aid a person who cannot independently self-administer medications. ~~See IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," Section 010.~~ (3-15-22)()

~~158. Mental Disorders.~~ Health conditions that are characterized by alterations in thinking, mood, behavior, or some combination thereof, that are all mediated by the brain and associated with distress or impaired functioning. (3-15-22)

~~169. Mental Illness.~~ Refers collectively to all diagnosable mental disorders. (3-15-22)

~~17. Neglect.~~ Failure to provide food, clothing, shelter, or medical care necessary to sustain the life and health of a resident. (3-15-22)

~~18. Negotiated Service Agreement.~~ The plan reached by the resident or their representative and the facility which outlines services to be provided and the obligations of the facility and the resident. (3-15-22)

~~19. Non-Core Issue.~~ Any finding of deficient practice that is not a core issue. (3-15-22)

~~20. Nursing Assessment.~~ Information gathered related to a resident's health or medical status that has been reviewed, signed, and dated by a licensed ~~registered~~ nurse, ~~as described in Section 305 of these rules.~~ (3-15-22)()

~~012. DEFINITIONS AND ABBREVIATIONS O THROUGH Z.~~

~~0121. Outside Services.~~ Services provided to a resident by someone that is not a member of facility personnel. (3-15-22)

~~0222. Owner.~~ Any person or entity having legal ownership of the facility as an operating business, regardless of who owns the real property. (3-15-22)

~~03. Personal Assistance.~~ The provision by the staff of the facility of one (1) or more of the following services: (3-15-22)

~~a. Assisting the resident with activities of daily living;~~ (3-15-22)

- ~~b.~~ Arranging for outside services; (3-15-22)
- ~~c.~~ Being aware of the resident's general whereabouts; or (3-15-22)
- ~~d.~~ Monitoring the activities of the resident while on the premises of the facility to ensure the resident's health, safety, and well-being. (3-15-22)
- ~~0423.~~ **Personnel.** Paid individuals assigned the responsibility of providing care, supervision, and services to the facility and its residents. In this chapter of rules, "personnel" and "staff" are synonymous. (3-15-22)
- ~~05.~~ **Physical Restraint.** Any device or physical force that restricts the free movement of, normal functioning of, or normal access to, a portion or portions of an individual's body, except for the temporary treatment of a medical condition, such as the use of a cast for a broken bone. (3-15-22)
- ~~0624.~~ **Portable Heating Device.** Any device designed to provide heat on a temporary basis that is not designed as part of a building's heating system, is not permanently affixed to the building, and, if electrical, is not hardwired to the building's electrical service. This does not include the use of therapeutic devices such as heating pads, heated mattress pads, and electric blankets, which require a physician or authorized provider's order. (3-15-22)
- ~~0725.~~ **PRN.** Indicates that a medication or treatment prescribed by a medical professional to an individual may be given as needed. (3-15-22)
- ~~08.~~ **Pressure Injury.** Any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). (3-15-22)
- ~~0926.~~ **Provisional License.** A license which may be issued to a facility not in compliance with the rules pending the satisfactory correction of all deficiencies. (3-15-22)
- ~~1027.~~ **Publicly Funded Program.** Any program funded in whole, or in part, by an appropriation of the U.S. Congress, the Idaho Legislature, or other governmental body. (3-15-22)
- ~~1128.~~ **Punishment.** The use of an adverse consequence with a resident, the administration of any noxious or unpleasant stimulus, or deprivation of a resident's rights or freedom. (3-15-22)
- ~~1229.~~ **Relative.** A person related by birth, adoption, or marriage. (3-15-22)
- ~~1330.~~ **Repeat Deficiency.** A deficiency found on a licensure survey, complaint investigation, or follow-up survey that was also found on the previous survey. (3-15-22)
- ~~1431.~~ **Reportable Incident.** A situation when a facility is required to report information to the Residential Assisted Living Facilities Program, including: (3-15-22)
- ~~a.~~ Any resident injury of unknown origin (i.e., an injury, the source of which was not observed by any person and could not be explained by the resident); (3-15-22)
- ~~ba.~~ Any resident injury of significant or suspicious nature (i.e., an injury that includes severe bruising, fingerprint bruises, laceration(s) larger than a minor skin tear, sprains, or fractured bones); (3-15-22)
- ~~c.~~ Resident injury resulting from accidents involving facility-sponsored transportation (i.e., falling from the facility's van lift, a wheelchair belt coming loose during transport, or a collision); (3-15-22)
- ~~db.~~ Resident elopement of any duration; (3-15-22)
- ~~ec.~~ Any significant injury resulting from a resident-to-resident incident; (3-15-22)()
- ~~fd.~~ An incident that results in the resident's need for assessment or treatment outside of the facility at a

- ~~hospital~~; or (3-15-22)()
- ~~ge.~~ An incident that results in the resident's death. (3-15-22)
- ~~15. Resident.~~ An adult, other than the owner, administrator, their immediate families, or employees, who lives in a residential assisted living facility. (3-15-22)
- ~~16. Residential Assisted Living Facility.~~ A facility or residence, however named, licensed in the state of Idaho, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. (3-15-22)
- ~~17. Room and Board.~~ Lodging, meals, and utilities. (3-15-22)
- ~~1832. Scope.~~ The frequency or extent of the occurrence of a deficiency in a facility. (3-15-22)
- ~~1933. Self-Administration of Medication.~~ The act of a resident taking a single dose of their own medication from a properly labeled container and placing it internally in, or externally on, their own body as a result of an order by an authorized provider. (3-15-22)
- ~~20. Story.~~ A level of rooms in a building. (3-15-22)
- ~~21. Substantial Compliance.~~ The status of a facility that has no core issue deficiencies. (3-15-22)
- ~~22. Substantial Evening Meal.~~ An offering of three (3) or more menu items at one time, one (1) of which is a high-quality protein such as meat, fish, eggs, or cheeses. The meal should represent no less than twenty percent (20%) of the day's total nutritional requirements. (3-15-22)
- ~~23. Supervision.~~ A critical watching and directing activity which provides protection, guidance, knowledge of the resident's general whereabouts, and assistance with activities of daily living. The administrator is responsible for providing appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements. (3-15-22)
- ~~2434. Survey.~~ A review conducted by a surveyor to determine compliance with statutes and rules. ~~There are two (2) components to a survey: (1) health care and (2) fire, life, and safety.~~ (3-15-22)()
- ~~2535. Surveyor.~~ A person authorized by the Department to conduct surveys or complaint investigations to determine compliance with statutes and rules. (3-15-22)
- ~~2636. Therapeutic Diet.~~ A diet ordered by a physician or authorized provider, including a licensed registered dietitian, as part of treatment for a clinical condition or disease, ~~to eliminate or decrease specific nutrients in the diet (e.g., sodium), to increase specific nutrients in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet).~~ (3-15-22)()
- ~~2737. Toxic Chemical.~~ A substance that is hazardous to health if inhaled, ingested, or absorbed through skin. (3-15-22)
- ~~2838. Traumatic Brain Injury (TBI).~~ An acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment. The term applies to open or closed-head injuries resulting in impairments in one (1) or more areas. (3-15-22)
- ~~2939. Unlicensed Assistive Personnel (UAP).~~ Staff, with or without formal credentials, employed to perform nursing care services under the direction and supervision of licensed nurses. (3-15-22)
- ~~3040. Variance.~~ Permission by the Department to do something contrary to rule. (3-15-22)
- ~~0131. -- 049. (RESERVED)~~

050. VARIANCES.

The Licensing Agency may grant a variance ~~provided the following criteria are met~~ to a rule provided the written requests meet the requirements under Title 67 Chapter 52, Idaho Code. (3-15-22)()

01. Written Request. A written request for a variance must be sent to the Licensing Agency. The request must include the following: (3-15-22)

a. Reference to the rule for which the variance is requested; (3-15-22)

b. ~~Reasons that show good cause why the variance should be granted, the extenuating circumstances which caused the need for the variance, any compensating factors or conditions that may have bearing on the variance such as additional floor space or additional staffing; and~~ (3-15-22)

e. Written documentation that ensures residents' health and safety will not be jeopardized if a variance is granted. (3-15-22)

021. Temporary Variance. A temporary variance may be granted for a specific resident or situation. The variance expires when the resident no longer lives at the facility or when the situation no longer exists. (3-15-22)()

032. Continuing A Variance. The Licensing Agency reviews the appropriateness of continuing a variance during the survey process. ~~If the facility administrator wishes to continue the variance, an annual request must be submitted to the Licensing Agency in writing.~~ (3-15-22)()

04. Decision to Grant a Variance. ~~The decision to grant a variance will not be considered as a precedent or be given any force or effect in any other proceeding.~~ (3-15-22)

053. Revocation of Variance. The Licensing Agency may revoke a variance if circumstances identify a risk to resident health and safety. (3-15-22)()

051. -- 099. (RESERVED)

100. LICENSING REQUIREMENTS.

01. Current License. No person, firm, partnership, association, corporation, or governmental unit can operate, establish, manage, conduct, or maintain a residential assisted living facility in Idaho without a license issued by the Department as required in Section 39-3340, Idaho Code. Any entity found operating as a residential assisted living facility without a license is subject to Section 39-3352, Idaho Code. (3-15-22)

021. Issuance of License. ~~Upon completion of the application process requirements, the Department will issue a residential assisted living facility license~~ A license will be issued to any organization upon completing an application demonstrating compliance with these rules. (3-15-22)()

032. Distinctive Business Name. Every facility must use a distinctive name, which is registered with the Idaho Secretary of State. ~~If a facility decides to change its name, it will only be changed upon written notification to the Licensing Agency confirming the registration of the name change with the Idaho Secretary of State. This notification needs to be received by the Licensing Agency at least thirty (30) calendar days prior to the date the proposed name change is to be effective~~ The facility will notify the Department within thirty (30) calendar days of a registered name change. (3-15-22)()

04. Administrator. Each facility must have an administrator. (3-15-22)

053. Display of Facility License. The current facility license must be posted in the facility and clearly visible to the general public. (3-15-22)

06. Change in Corporate Shares. When there is a significant change in shares held by a corporate licensee of a residential assisted living facility, which does not alter the overall ownership or operation of the

~~business, that change must be communicated to the Licensing Agency within (60) days of the effective date of change.~~ (3-15-22)

~~074.~~ **Licensee Responsibility.** The licensee of the facility is responsible for the operation of the residential assisted living facility, ~~even when a separate administrator is employed.~~ (3-15-22)()

~~101. --104.~~ **(RESERVED)**

~~105.~~ **CHANGE OF OWNERSHIP.**

~~01.~~ **Non Transfer of Facility License.** A facility license is not transferable from one (1) individual to another, from one (1) business entity to another, or from one (1) location to another. When a change of licensee, ownership, lease, or location occurs, the facility must be re-licensed. The new licensee must follow the application procedures, and obtain a license, before commencing operation as a facility. (3-15-22)

~~02.~~ **Application for Change of Ownership.** The application for a change of ownership must be submitted to the Licensing Agency at least ninety (90) days prior to the proposed date of change. (3-15-22)

~~03.~~ **Change of Ownership for a Facility in Litigation.** An application for change of ownership of a facility from a person who is in litigation for failure to meet licensure standards, or who has had a license revoked, must include evidence that there is a bona fide, arms-length agreement and relationship between the two (2) parties. An entity purchasing a facility with an enforcement action acquires the enforcement action. (3-15-22)

~~106.--~~ 109. **(RESERVED)**

110. FACILITY LICENSE APPLICATION.

01. License Application. License application forms are available online at the Licensing Agency's website at <http://assistedliving.dhw.idaho.gov>. The applicant must provide the following information: (3-15-22)

~~a.~~ A written statement that the applicant has thoroughly read and reviewed the statute, Title 39, Chapter 33, Idaho Code, and IDAPA 16.03.22, "Residential Assisted Living Facilities," and is prepared to comply with both; (3-15-22)

~~b.~~ A written statement and documentation that demonstrate no license revocation or other enforcement action is in the process of being taken, against a license held, or previously held, by the applicant in Idaho or any other state or jurisdiction; (7-1-24)

~~c.~~ When the applicant is a firm, association, organization, partnership, business trust, corporation, government entity, or company, the administrator and other members of the organization who directly influence the facility's operation must provide the information contained in this rule; (3-15-22)

~~d.~~ Each shareholder or investor holding twenty percent (20%) or more interest in the business must be listed on the application; (7-1-24)

~~ea.~~ A copy of the Certificate of Assumed Business Name from the Idaho Secretary of State; (3-15-22)

~~f.~~ A statement from the local fire authority that the facility is located in a lawfully constituted fire district or affirmation that a lawfully constituted fire authority will respond to a fire at the facility; (3-15-22)

~~g.~~ A statement from a licensed electrician or the local or state electrical inspector that all wiring in the facility complies with current electrical codes; (3-15-22)

~~h.~~ When the facility does not use an approved municipal water or sewage treatment system, a statement from a local environmental health specialist with the public health district indicating that the water supply and sewage disposal system meet the Department's requirements and standards; (3-15-22)

- ib.** A complete set of printed operational policies and procedures; (3-15-22)
- j.** A detailed floor plan of the facility, including measurements of all rooms, or a copy of architectural drawings. See Sections 250 through 260, and Sections 400 through 430 of these rules. (3-15-22)
- kc.** A copy of the Purchase Agreement, Lease Agreement, or Deed; and (3-15-22)()
- l.** For facilities with nine (9) beds or more, signatures must be obtained from the following: (3-15-22)
- d.** A detailed floor plan of the facility, including measurements of all rooms, or a copy of architectural drawings; and ()
- e.** The following must be obtained: ()
- i. The local zoning official documenting that the facility meets local zoning codes for occupancy; Occupancy permit that the facility is located in a lawfully constituted fire district or affirmation that a lawfully constituted fire authority will respond to a fire at the facility; (3-15-22)()
- ii. The local building official documenting that the facility meets local building codes for occupancy; and Occupancy permit that all wiring in the facility complies with current electrical codes; (3-15-22)()
- iii. The Occupancy permit or evidence that the facility meets local zoning codes for occupancy and local fire official documenting that the facility meets local fire codes for occupancy. (3-15-22)()
- 02. Written Request for Building Evaluation.** The applicant ~~must request~~ submits a request in writing to the Licensing Agency for a building evaluation ~~of existing buildings. The request.~~ It must include the physical address of the building ~~that is to be evaluated and,~~ the name, address, and telephone number of the person who is to receive the building evaluation report, and be accompanied by a five hundred dollar (\$500) initial building evaluation fee. (3-15-22)()
- 03. Building Evaluation Fee.** This application and request ~~must be accompanied by a five hundred dollar (\$500) initial building evaluation fee.~~ (3-15-22)
- 043. Identification of the Licensed Administrator.** The applicant must provide a copy of the administrator's license and criminal history background check, ~~and the current address for the primary residence of the administrator.~~ (3-15-22)()
- 05. Failure to Complete Application Process.** Failure of the applicant to complete the Licensing Agency's application process within six (6) months of the original date of application, may result in a denial of the application. If the application is denied, the applicant is required to initiate a new licensing application process. (3-15-22)

111. -- 114. (RESERVED)

115. EXPIRATION AND RENEWAL OF LICENSE.

- 01. Application for License Renewal.** The facility must submit to the Licensing Agency an annual report and application for renewal of a license at least thirty (30) days prior to the expiration of the existing license. (3-15-22)
- 02. Existing License.** The existing license, unless suspended, surrendered, or revoked, remains in force and effect until the Licensing Agency has acted upon the application renewal, when such application for renewal has been filed. (3-15-22)

116. -- 125. (RESERVED)

126. EFFECT OF ENFORCEMENT ACTION AGAINST A LICENSE.

The Department will not review an application of an applicant who has an action, either current or in process, against a license held by the applicant ~~either in Idaho or any other state or jurisdiction.~~ (3-15-22)()

127. FREQUENCY OF INSPECTIONS.

01. No Core Issues. Facilities without core issue deficiencies during two (2) consecutive licensure surveys, will be inspected at least every thirty-six (36) months. For facilities with core issue deficiencies, surveys will be conducted at the discretion of the Licensing Agency, at least every fifteen (15) months. ()

02. Complaint Investigations. Complaint investigations will occur based on the severity of the complaint. ()

03. Correction of Non-Core Issues. The facility must correct non-core issues within thirty (30) calendar days of the exit conference. If the facility is unable to meet this timeframe, they must inform the Department within thirty (30) calendar days of the exit conference. ()

~~127~~8. – ~~149~~50. (RESERVED)

150. POLICIES AND PROCEDURES.

The facility must develop a written, dated set of policies and procedures that are specific to the population served in the facility and are available to all staff at all times to direct and ensure compliance with these rules. Policy topics must include abuse, neglect, exploitation, incidents and accidents, activities, admissions, emergency preparedness, infection control, nursing, resident rights, staffing, and medications. (3-15-22)

151. ACTIVITY REQUIREMENTS.

Each facility must develop and implement a written activity policy that ~~assists~~, encourages, and promotes residents to maintain and develop their highest potential for independent living through their participation participate in planned, recreational, and other activities. ~~The facility must provide opportunities for the following:~~ (3-15-22)()

~~01. Socialization.~~ Socialization through group discussion, conversation, recreation, visiting, arts and crafts, and music; (3-15-22)

~~02. Physical Activities.~~ Physical activities such as games, sports, and exercises which develop and maintain strength, coordination, and range of motion; (3-15-22)

~~03. Education.~~ Education through special classes or events; and (3-15-22)

~~04. Community Resources for Activities.~~ The facility will utilize community resources to promote resident participation in integrated activities of their choice both in and away from the facility. (3-15-22)

152. ADMISSION REQUIREMENTS.

01. Admissions Policies. Each facility must develop and implement written admission policies and procedures, which must include: (3-15-22)

a. The purpose, quantity, and characteristics of available services; (3-15-22)

b. Limitations concerning delivery of routine personal care by persons of the opposite gender; (3-15-22)

c. Notification to potential and existing residents and responsible parties if the facility accepts any residents who are on the sexual offender registry. The registry may be accessed online at <http://isp.idaho.gov/sor-id/search.html>; and (3-15-22)

d. Notification to potential and existing residents if non-resident adults or children reside in the

facility. (3-15-22)

02b. Resident Admission, Discharge, and Transfer. The facility must have policies Criteria for addressing admission, discharge, and transfer of residents to, from, or within the facility. (3-15-22)()

032. Policies of Acceptable Admissions. ~~Written descriptions of the conditions~~ Policies for admitting residents to the facility must include: (3-15-22)()

a. A resident will be admitted or retained only when: (3-15-22)

ia. The facility has the capability, capacity, and services to provide appropriate care; (3-15-22)

ib. The resident does not require a type of service for which the facility is not licensed to provide or which the facility does not provide or arrange for; and (3-15-22)

ic. The facility has the personnel, appropriate in numbers and with appropriate knowledge and skills to provide such services. (3-15-22)

153. FINANCIAL REQUIREMENTS.

Each facility must develop and implement financial policies and procedures that include: (3-15-22)

01. Statement Resident Funds. ~~A statement policy~~ specifying if how the facility ~~does not will~~ manage resident funds. (3-15-22)()

02. Safeguarding of Funds. ~~Policies should s~~ Specify how residents' funds will be ~~handled~~ managed and safeguarded, and be in compliance with Section 39-3316, Idaho Code. ~~if~~ If the facility does manage resident funds, ~~p~~ policies must address the following: (3-15-22)()

a. When a resident's funds are deposited with, or handled by the facility, ~~the funds must be managed as described in Section 39-3316, Idaho Code, and Section 550 of these rules;~~ (3-15-22)

b. A description of how facility fees are handled; (3-15-22)

c. Resident accounts and funds must be separate from any facility accounts; (3-15-22)

da. The facility cannot require a resident to purchase goods or services from the facility, other than items specified in the admission agreement and facility policies; (3-15-22)

eb. Each transaction ~~with resident funds~~ must ~~be documented at the time to include signatures of the resident and facility representative with copies of receipts;~~ include copies of receipts. (3-15-22)()

f. Residents must have access to their personal funds during normal business hours; and (3-15-22)

g03. Funds at Discharge. When a resident permanently leaves the facility, the facility can only retain room and board funds prorated to the last day of the thirty (30) day notice, ~~except in situations described in Sections 247 and 550 of these rules.~~ Per the admissions agreement, the facility may charge a fee for the repair of damages or cleaning the room. All remaining funds are the property of the resident. (3-15-22)()

154. ~~STAFF TRAINING~~ RESIDENT SAFETY REQUIREMENTS.

The facility must develop ~~and implement~~ a written, dated set of policies and procedures that are specific to the populations served in the facility and are available to all staff at all times to direct and ensure compliance with these rules. The facility must develop and implement policies and procedures to address the following: (3-15-22)()

01. Response of Staff to Accidents, Incidents, or Allegations of Abuse, Neglect, or Exploitation of Residents. ~~The facility must develop policies and procedures to ensure that~~ This includes how accidents, incidents, or allegations of abuse, neglect, and exploitation are identified, documented, reported, investigated, and followed-up with interventions to prevent re-occurrence and ensure protection. (3-15-22)()

02. Response of Staff to Emergencies. ~~How staff are to respond to~~ Staff responsibilities in emergency situations, including: (3-15-22)()

- a. Medical and psychiatric emergencies; (3-15-22)
- b. Resident absence; (3-15-22)
- c. Criminal situations; and (3-15-22)
- d. Presence of law enforcement officials at the facility. (3-15-22)

03. Notification of Changes to Resident Health or Mental Status. ~~Who and how staff are to notify of~~ Staff responsibilities and notification requirements for any changes in residents' health or mental status. (3-15-22)()

04. Provided Care and Services by Staff. ~~How s~~ Staff are to provide responsibilities when providing care and services to residents in the following areas: (3-15-22)()

- a. Activities of daily living; (3-15-22)
- b. Dietary and eating, including when a resident refuses to eat or follow a prescribed diet; (3-15-22)
- c. Dignity; (3-15-22)
- d. Ensuring each individual's rights; (3-15-22)
- e. Medication assistance; (3-15-22)
- f. Provision of privacy; (3-15-22)
- g. Social activities; (3-15-22)
- h. Supervision; (3-15-22)
- i. Supporting resident independence; and (3-15-22)
- j. Telephone access. (3-15-22)

~~**05. Intervention Procedures to Ensure Safety of Residents and Staff.** How to intervene to ensure resident and staff safety in unsafe situations that are physically or behaviorally caused.~~ (3-15-22)

065. Behavior Management for Residents. The facility must have policies and procedures to ensure staff are trained and complete timely assessment, plan development, and documentation as described in Section 330 of these rules. (3-15-22)

~~**076. Facility Operations, Inspections, Maintenance, and Testing.** Plans and procedures for the operation, periodic inspection, and testing of the physical plant, which includes utilities, fire safety, and plant maintenance for all areas of the facility's campus.~~ (3-15-22)

~~**087. Hazardous Materials.** The handling of hazardous materials.~~ (3-15-22)

~~**098. Mechanical Equipment.** The handling of potentially dangerous mechanical equipment.~~ (3-15-22)

09. Smoking Requirements. The facility must develop and implement written rules governing smoking. Smoking policies must be available to staff, residents, and visiting public and must ensure: ()

a. Smoking is prohibited in areas where combustible supplies or materials, flammable liquids, gases, or oxidizers are in use or stored. ()

b. Smoking in bed is prohibited. ()

c. Unsupervised smoking by residents classified as not mentally or physically responsible, sedated by medication, or taking oxygen is prohibited. ()

d. If smoking is permitted, there must be designated smoking areas which are clearly marked. Designated smoking areas must have non-combustible disposal receptacles. ()

155. EMERGENCY PREPAREDNESS REQUIREMENTS.

Each facility must develop and implement an emergency preparedness plan ~~to follow~~ in the event of fire, explosion, flood, earthquake, high wind, natural disaster, or other emergency. (3-15-22)()

01. Relocation Agreements. Each facility must have a current written agreement developed between the facility and two (2) separate locations to which residents would be relocated in the event the building is evacuated and cannot be reoccupied. ~~The facility will review the relocation agreements annually.~~ (3-15-22)()

02. Written Procedures. The facility must have written procedures outlining steps to be taken in the event of an emergency including: (3-15-22)

a. Each person's responsibilities; (3-15-22)

b. Where and how residents are to be evacuated; and (3-15-22)

c. Notification of emergency agencies. (3-15-22)

03. Emergency Generators. ~~Facilities that elect to have an emergency generator must ensure that the system is designed to meet the applicable codes in NFPA, Standard 110 (within NFPA, Standard 101 as incorporated in Section 004 of these rules).~~ (3-15-22)

156. HOURLY ADULT CARE REQUIREMENTS.

Facilities offering hourly adult care must develop and implement written policies and procedures which include the following: (3-15-22)

01. Services Offered. A description of hourly adult care services, including transportation services (if offered), meals, medical assistance, activities, ~~and~~ supervision, and documentation requirements. (3-15-22)()

02. Individuals Accepted. ~~Types of individuals who may or may not be accepted for hourly adult care. See Section 152 of these rules.~~ (3-15-22)

03. Cost of Hourly Adult Care. ~~Details of the cost of hourly adult care for the person receiving services.~~ (3-15-22)

04. Hours for Care. ~~The specific time periods of hourly adult care, not to exceed fourteen (14) consecutive hours in a twenty-four (24) hour period.~~ (3-15-22)

05. Assistance with Medications. ~~Assistance with medications in the facility must comply with IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," including:~~ (3-15-22)

a. ~~Copies of all physician or authorized provider orders, including orders for all prescribed medications and treatments.~~ (3-15-22)

b. ~~Appropriately labeled medications and treatments the facility safeguards while the person receives hourly adult care.~~ (3-15-22)

02. Hourly Adult Care. The facility must keep record of names, dates, and description of services provided. ()

~~063.~~ **Staffing.** Staffing must be based on the needs of the entire facility, including those receiving hourly adult care and residents. Hourly adult care may be provided to as many individuals as possible without disrupting the day-to-day operations and normal activities of the facility. (3-15-22)

~~074.~~ **Accommodations.** The facility must provide accommodations appropriate to the time frame for those receiving hourly adult care, ~~including:~~ (3-15-22)()

~~a. Daytime accommodations such as recliners and couches for napping. Napping furniture must be spaced at least (3) feet apart. (3-15-22)~~

~~b. Evening accommodations such as beds and bedrooms that are not used by facility residents. Any bed used overnight by a person receiving hourly adult care will not be counted as a licensed bed. (3-15-22)~~

~~08. Documentation.~~ Documentation requirements described in Section 330 of these rules. (3-15-22)

~~157. --160. (RESERVED)~~

~~161. SMOKING REQUIREMENTS.~~

~~The facility must develop and implement written rules governing smoking. Nothing in this rule requires a facility to permit smoking. Smoking policies must be made known to all staff, residents, and visiting public and must ensure: (3-15-22)~~

~~01. Combustible Supplies and Flammable Items.~~ Smoking is prohibited in areas where combustible supplies or materials, flammable liquids, gases, or oxidizers are in use or stored. (3-15-22)

~~02. Smoking in Bed.~~ Smoking in bed is prohibited. (3-15-22)

~~03. Unsupervised Smoking.~~ Unsupervised smoking by residents classified as not mentally or physically responsible, sedated by medication, or taking oxygen is prohibited. (3-15-22)

~~04. Designated Smoking Areas.~~ If smoking is permitted, there must be designated smoking areas which are specified in policy and clearly marked. Designated smoking areas must have non-combustible disposal receptacles. (3-15-22)

~~162. — 215. (RESERVED)~~

216. REQUIREMENTS FOR RESIDENT ~~ADMISSION AGREEMENTS.~~

~~01. Initial Resident Assessment and Care Plan.~~ Prior to admission, each resident must be assessed by the facility to ensure the resident is appropriate for placement in their residential assisted living facility. The facility must develop an interim care plan to guide services until the facility can complete the resident assessment process. The result of the assessment will determine the need for specific services and supports. (3-15-22)

01. Pre-Admission. Prior to admission, each resident must be assessed by the facility to ensure the resident is appropriate for placement in their residential assisted living facility. The assessment must include the following: ()

a. Documentation of level of assistance required for activities of daily living including bathing, dressing, toileting, grooming, eating, communicating and the use of adaptive equipment; ()

b. Pre-admission nursing assessment; ()

c. Documentation of any maladaptive behaviors including history, intensity, duration, and frequency,

including potential contributing factors and mitigation efforts; and ()

d. Documentation of the need for related outside services, including service type, name and frequency. ()

02. **Written Agreement.** Prior to, or on the day of admission, the facility and each resident or the resident's legal guardian or conservator must enter into a written admission agreement ~~that is transparent, understandable, and is translated into a language the resident or their representative understands. The admission agreement will provide a complete reflection of the facility's charges, commitments agreed to by each party, and the actual practices that will occur in the facility. The agreement must be signed by all involved parties, and a complete copy provided to the resident and the resident's legal guardian or conservator prior to, or on the day of admission. The admission agreement may be integrated within the Negotiated Service Agreement (NSA), provided that all requirements for the NSA in Section 320 of these rules and the admission agreement are met. Admission agreements must include all items described under this rule.~~ The admission agreement will provide a complete reflection of the facility's charges, commitments agreed to by each party, and the services to be provided by the facility. The agreement must include the following: (3-15-22)()

03. **Services, Supports, and Rates.** The facility must identify the following services, supports, and applicable rates: (3-15-22)

a. Unless otherwise negotiated with the resident or the resident's legal guardian or conservator, basic services must include the items specified in Section 430 of these rules. (3-15-22)

b. The resident's monthly charges, including a specific description of the services that are included in the basic services rate and the charged rate. (3-15-22)

c. All prices, formulas, and calculations used to determine the resident's basic services rate including: (3-15-22)

i. Service packages; (3-15-22)

ii. Fee-for-service rates; (3-15-22)

iii. Assessment forms; (3-15-22)

iv. Price per assessment point; (3-15-22)

v. Charges for levels of care determined with an assessment; and (3-15-22)

vi. Move-in fees or other similar charges. (3-15-22)

d. The services and rates charged for additional or optional services, supplies, or amenities that are available through the facility or arranged for by the facility for which the resident will be charged additional fees. (3-15-22)

e. Services or rates that are impacted by an updated assessment of the resident, the assessment tool, the assessor, and the frequency of the assessment, when the facility uses this assessment to determine rate changes. (3-15-22)

f. The facility may charge residents for the use of personal furnishings, equipment, and supplies provided by the facility unless paid for by a publicly funded program. The facility must provide a detailed itemization of furnishings, equipment, supplies, and the rate for those items the resident will be charged. (3-15-22)

04a. **Staffing.** The agreement must identify staffing patterns and qualifications of staff on duty during a normal day. (3-15-22)()

05. **Notification of Liability Insurance Coverage.** The administrator of a residential assisted living

~~facility must disclose in writing at the time of admission or before a resident's admission if the facility does not carry professional liability insurance. If the facility cancels the professional liability insurance all residents must be notified of the change in writing.~~ (3-15-22)

~~06b. Medication Responsibilities. The agreement must i~~Identify the facility's and resident's roles and responsibilities relating to assistance with medications including the reporting of missed medications or those taken on a PRN basis. (3-15-22)()

~~07c. Resident Personal Fund Responsibilities. The agreement must i~~Identify who is responsible for the resident's personal funds. (3-15-22)()

~~08d. Resident Belongings Responsibility. The agreement must i~~Identify responsibility for protection and disposition of all valuables belonging to the resident and provision for the return of the resident's valuables if the resident leaves the facility. (3-15-22)()

~~09e. Emergency Transfers. The agreement must i~~Identify conditions under which emergency transfers will be made as provided in Section 152 of these rules. (3-15-22)()

~~10f. Billing Practices, Notices, and Procedures for Payments and Refunds. The facility must~~
~~p~~Provide a description of the facility's billing practices, notices, and procedures for payments and refunds. The following procedures must be included: (3-15-22)()

~~a~~i. Arrangement for payments; (3-15-22)

~~b~~ii. Under what circumstances and time frame a partial month's resident fees are to be refunded when a resident no longer resides in the facility; and (3-15-22)

~~c~~iii. Written notice to vacate the facility must be given thirty (30) calendar days prior to transfer or discharge on the part of either party, except in the case of the resident's emergency discharge or death. The facility may charge up to fifteen (15) days prorated rent from the date of the resident's emergency discharge or death. The agreement must disclose any charges that will result when a resident fails to provide a thirty (30) day written notice. (3-15-22)

~~11g. Resident Permission to Transfer Information. The agreement must s~~Specify permission for the facility to transfer information from the resident's records to any facility to which the resident transfers. (3-15-22)()

~~12h. Resident Responsibilities. The agreement must s~~Specify resident responsibilities. (3-15-22)()

~~13i. Restrictions on Choice of Care or Service Providers. The agreement must s~~Specify any restriction on choice of care or service providers, such as home health agency, hospice agency, or personal care services. (3-15-22)()

~~14j. Advance Directive. The agreement must i~~Identify written documentation of the resident's preference regarding the formulation of an advance directive in accordance with Idaho state law. When a resident has an advance directive, a copy must be immediately available for staff and emergency personnel. (3-15-22)()

~~15. Notification of Payee Requirements. The agreement must identify if the facility requires as a condition of admission that the facility be named as payee.~~ (3-15-22)

~~16k. Contested Charges. The facility must p~~Provide the methods by which a resident may contest charges or rate increases including contacting the ombudsman for the elderly. (3-15-22)()

~~17l. Transition to Publicly Funded Program. The facility must d~~Disclose the conditions under which the resident can remain in the facility if payment for the resident shifts to a publicly funded program. (3-15-22)()

- ~~18m.~~ ~~Smoking Policy.~~ The admission agreement must ~~i~~include a copy of the facility's smoking policy. (3-15-22)()

217. REQUIREMENTS FOR TERMINATION OF ADMISSION AGREEMENT.

~~01. Conditions for Termination of the Admission Agreement.~~ The admission agreement cannot be terminated, except under Section 39-3313, Idaho Code, as follows: (3-15-22)

- ~~a. Giving the other party thirty (30) calendar days written notice;~~ (3-15-22)
- ~~b. The resident's death;~~ (3-15-22)
- ~~c. Emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from harm;~~ (3-15-22)
- ~~d. The resident's mental or medical condition deteriorates to a level requiring care as described in Section 39-3307, Idaho Code, and Section 152 of these rules;~~ (3-15-22)
- ~~e. Nonpayment of the resident's fees;~~ (3-15-22)
- ~~f. When the facility cannot meet resident needs due to changes in services, in-house or contracted, or inability to provide the services; or~~ (3-15-22)
- ~~g. Other written conditions as may be mutually established between the resident, the resident's legal guardian or conservator, and the administrator of the facility at the time of admission.~~ (3-15-22)

01. Notification. Before a facility discharges a resident, the facility must notify the resident or their representative in writing and their representative of the discharge and the cause. ()

02. Facility Responsibility During Resident Discharge. The facility is responsible to assist the resident with transfer by providing a list of skilled nursing facilities, other residential assisted living facilities, and certified family homes that may meet the needs of the resident. ~~The facility must provide a copy of the resident record, as described in Section 330 of these rules, within two (2) business days of receipt of a request signed and authorized by the resident or legal representative.~~ (3-15-22)()

~~03. Resident's Appeal of Involuntary Discharge.~~ A resident may appeal all discharges, with the exception of an involuntary discharge in the case of nonpayment or emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from harm. (3-15-22)

~~a. Before a facility discharges a resident, the facility must notify the resident and their representative of the discharge and the cause.~~ (3-15-22)

~~b. This notice must be in writing and in a language and manner the resident or their representative can understand.~~ (3-15-22)

043. Written Notice of Discharge. The written notice of discharge must include the following: (3-15-22)

- a.** The specific reason for the discharge; (3-15-22)
- b.** The effective date of the discharge; (3-15-22)
- c.** A statement that the resident has the right to appeal the discharge to the Department within thirty (30) calendar days of receipt of written notice of discharge; (3-15-22)
- dc.** The Residential Assisted Living Facilities Program website, where the appeal must be submitted A statement informing the resident of their appeal rights including timelines and methods; (3-15-22)()

- ed.** The name, address, and telephone number of the local ombudsman; (3-15-22)
- fe.** The name, address, and telephone number of Disability Rights Idaho; (3-15-22)
- gf.** If the resident fails to pay fees to the facility, ~~as agreed to in the admission agreement~~, during the discharge appeal process, the resident's appeal of the involuntary discharge becomes null and void and the discharge notice applies; and (3-15-22)()
- hg.** When the notice does not contain all the above required information, the notice is void and must be reissued. (3-15-22)

04. Resident's Appeal of Involuntary Discharge. A resident may appeal all discharges, with the exception of an involuntary discharge in the case of nonpayment or emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from harm. ()

05. Receipt of Appeal. Request for an appeal must be received by tThe Department must receive the appeal request within thirty (30) calendar days of the resident's or resident's representative's receipt of written notice of discharge to stop the discharge before it occurs receipt of written notice of discharge. (3-15-22)()

218. -- 249. (RESERVED)

250. REQUIREMENTS FOR BUILDING CONSTRUCTION AND PHYSICAL STANDARDS.

~~Minimum construction must meet all requirements of this rule to include codes and standards incorporated by reference in Section 004 of these rules, and all local and state codes that are applicable to residential assisted living facilities. Where there are conflicts between the requirements in the codes, the most restrictive condition must apply.~~ (3-15-22)

01. Construction Changes. For all new construction, changes of occupancy, modifications, additions, or renovations to existing buildings, the facility must submit construction drawings with specifications to the licensing authority for review and approval prior to any work being started. All new construction and conversions must install audible and visual notification devices for fire alarm systems in all common areas and resident rooms no matter the size of facility. (3-15-22)

02. Plans and Specifications. Plans must be prepared, signed, stamped, and dated by an architect or engineer licensed in the state of Idaho. ~~A variance of this requirement may be granted by the Licensing Agency when the size of the project does not necessitate involvement of an architect or engineer. This must include the following: and submitted to the Department after approval of local authorities.~~ (3-15-22)()

~~**a:** Plans and specifications must be submitted to the Licensing Agency to ensure compliance with applicable construction standards, codes, and regulations;~~ (3-15-22)

~~**b:** Plans must be drawn to scale, but no less than a scale of one-eighth (1/8) inch to one (1) foot;~~ (3-15-22)

~~**c:** Plans must be submitted electronically;~~ (3-15-22)

~~**d:** A physical address approved by the city;~~ (3-15-22)

~~**e:** Life safety plans;~~ (3-15-22)

~~**f:** Fire alarm shop drawings; and~~ (3-15-22)

~~**g:** Fire sprinkler system drawings and calculations.~~ (3-15-22)

03. Approval. All buildings, additions, and renovations are subject to approval by the Licensing Agency and must meet applicable requirements. (3-15-22)

~~04. Walls and Floor Surfaces.~~ Walls and floors must be of such character to permit cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have washable surfaces. (3-15-22)

~~054. Toilets and Bathrooms.~~ Each facility must provide: (3-15-22)

~~a.~~ A toilet and bathroom for resident use so arranged that it is not necessary for an individual to pass through another resident's room to reach the toilet or bath; (3-15-22)

~~b.~~ Solid walls or partitions to separate each toilet and bathroom from all adjoining rooms; (3-15-22)

~~c.~~ Mechanical ventilation to the outside from all inside toilets and bathrooms not provided with an operable exterior window; (3-15-22)

~~d.~~ ~~Each tub, shower, and lavatory with hot and cold running water~~ Adequate number of bathrooms to meet the needs of the residents admitted to the facility; (3-15-22)()

~~e.~~ At least one (1) flushing toilet for every six (6) residents; (3-15-22)

~~f.~~ At least one (1) tub or shower for every eight (8) residents; (3-15-22)

~~g.~~ At least one (1) lavatory with a mirror for each toilet; and (3-15-22)

~~h.~~ At least one (1) toilet, tub or shower, and lavatory in each building in which residents sleep, with additional units if required by the number of persons. (3-15-22)

~~065. Accessibility for Persons with Mobility and Sensory Impairments.~~ For residents who have mobility or sensory impairments, the facility must provide a physical environment which meets the needs of the person for independent mobility and use of appliances, bathroom facilities, and living areas. New construction must meet the requirements of the Americans with Disabilities Act Accessibility Guidelines (ADAAG). Existing facilities must comply, to the maximum extent feasible, ~~with 28 CFR Sections 36.304 and 36.305 regarding removal of barriers under the Americans with Disabilities Act, without creating an undue hardship or burden on the facility, and must provide as required, the necessary accommodations.~~ (3-15-22)()

~~a.~~ Ramps for residents who require assistance with ambulation must comply with the requirements of the ADAAG 4.8; (3-15-22)

~~b.~~ Bathrooms and doors large enough to allow the easy passage of a wheelchair as provided for in the ADAAG 4.13; (3-15-22)

~~c.~~ Grab bars in resident toilet and bathrooms in compliance with ADAAG 4.26; (3-15-22)

~~d.~~ Toilet facilities in compliance with ADAAG 4.16 and 4.23; (3-15-22)

~~e.~~ Non-retractable faucet handles in compliance with ADAAG 4.19, with the exception of self-closing valves under 4.19.5, and 4.27; and (3-15-22)

~~f.~~ A suitable hand railing must be provided on both sides of all stairs leading into and out of a building for residents who require the use of crutches, walkers, or braces. (3-15-22)

~~07. Lighting.~~ The facility must provide adequate lighting in all resident sleeping rooms, dining rooms, living rooms, recreation rooms, and hallways. (3-15-22)

~~08. Ventilation.~~ The facility must be ventilated, and precautions taken to prevent offensive odors. (3-15-22)

~~096. Plumbing.~~ All plumbing in the facility must comply with local and state codes. All plumbing

~~fixtures must be easily cleanable and maintained in good repair.~~ The temperature of hot water at plumbing fixtures used by residents must be between one hundred five degrees Fahrenheit (105°F) and one hundred twenty degrees Fahrenheit (120°F). (3-15-22)()

~~1907.~~ **Heating, Ventilation, and Air-Conditioning (HVAC).** Equipment must be furnished, installed, and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes. An HVAC system must be ~~provided for the facility that is~~ capable of maintaining a minimum temperature of seventy degrees Fahrenheit (70°F) and a maximum temperature of seventy-eight degrees Fahrenheit (78°F) during the day, and a minimum of sixty-two degrees Fahrenheit (62°F) and a maximum temperature of seventy-five degrees Fahrenheit (75°F) during the night. Wood stoves, gas fireplaces, or solid burning fireplaces are not permitted as the sole source of heat, and the thermostat for the primary source of heat must be remotely located away from any of these sources. (3-15-22)()

a. Portable heating devices of any kind are prohibited. ~~Portable electric space heaters and movable fuel-fired heaters are considered portable comfort heating devices. Exceptions are heated mattress pads, electric blankets, and heating pads when ordered by an authorized provider or physician~~ in resident sleeping areas; (3-15-22)()

b. All fireplaces must provide a safety barrier ~~and have heat-tempered glass fireplace enclosures equivalent to ASTM Standard~~ that is tip resistant and ensures resident safety; (3-15-22)()

c. Boilers, hot water heaters, and unfired pressure vessels must be equipped with automatic pressure relief valves; (3-15-22)

d. Fire and smoke dampers must be inspected, serviced, and cleaned once every four (4) years by a person professionally engaged in the business of servicing these devices or systems. A copy of these results must be kept in the facility. (3-15-22)

~~1108.~~ **Dining, Recreation, Shower, Bathing, and Living Space.** The total area set aside for these purposes must be no less than thirty (30) square feet per licensed bed. A hall or entry cannot be included as living or recreation space. (3-15-22)

~~1209.~~ **Resident Sleeping Rooms.** The facility must ensure that: (3-15-22)

~~a:~~ Resident sleeping rooms are not in attics, stairs, halls, or any other room commonly used for other than bedroom purposes; (3-15-22)

~~b:~~ A room with a window that opens into an exterior window well cannot be used for a resident sleeping room; (3-15-22)

~~ea.~~ Not more than ~~four~~ two (42) residents can be housed in any multi-bed sleeping room ~~in facilities licensed prior to July 1, 1991. New facilities or buildings converted to a licensed facility after July 1, 1991, cannot have more than two (2) residents in any multi-bed sleeping room. When there is any change in ownership of the facility, the maximum number of residents allowed in any room is two (2);~~ (3-15-22)()

~~db.~~ Square footage requirements for resident sleeping rooms must provide for not less than one hundred (100) square feet of floor space per resident in a single-bed sleeping room and not less than eighty (80) square feet of floor space per resident in a multi-bed sleeping room. For facilities constructed after January 1, 2021, square footage requirements for resident sleeping rooms must provide at least one hundred (100) square feet of floor space per resident for both single-bed and multi-bed sleeping rooms. (3-15-22)

~~e:~~ Each resident's sleeping room must be provided with an operable exterior window. An operable window is not required where there is a door directly to the outside from the sleeping room; (3-15-22)

~~f:~~ The operable window sill height must not exceed thirty-six (36) inches above the floor in new construction, additions, or remodeling; (3-15-22)

~~gc.~~ The operable window-sill height must not exceed forty-four (44) inches above the floor in existing buildings being ~~converted to a facility~~; (3-15-22)()

~~h.~~ Each resident sleeping room must provide a total window space that equals at least eight percent (8%) of the room's total square footage; (3-15-22)

~~id.~~ Window screens must be provided on operable windows; ~~and~~ (3-15-22)()

~~j.~~ Resident sleeping rooms must have walls that run from floor to ceiling, have doors that will limit the passage of smoke, and provide the resident(s) with privacy; (3-15-22)

~~k.~~ Ceiling heights in sleeping rooms must be at least seven (7) feet, six (6) inches; and (3-15-22)

~~le.~~ Closet space in each resident sleeping room must provide at least four (4) usable square feet per resident. Common closets used by two (2) or more residents must have substantial dividers for separation of each resident's clothing. All closets must be equipped with doors. Free-standing closets are deducted from the square footage of the sleeping room. (3-15-22)

130. Secure Environment. If the facility accepts and retains residents who have cognitive impairment and have a history of elopement or attempted elopement, the facility must provide an interior environment and exterior yard that is secure and safe. ~~Because measures to secure the environment may be effective for one (1) resident, but not another, the type of the security provided must be evaluated for effectiveness in protecting each resident, based on their individual needs and abilities, and adjusted as necessary. These measures must be incorporated into the NSA of each applicable resident. The secured environment and security provided must be evaluated and adjusted as necessary to meet the needs of all residents.~~ (3-15-22)()

141. Call System. The facility must have a call system available for each resident ~~to call for assistance~~ and ~~still be ensured a~~ maintain the resident's right to privacy ~~at the facility~~, including in the resident's living quarters and common areas, during medical treatment, and other services, and in written and telephonic communications, or in visits with family, friends, advocates, and resident groups. The call system cannot be a substitute for supervision. ~~For facilities licensed prior to January 1, 2006, when the current system is no longer operational or repairable the facility must install a call system as defined in Section 010 of these rules.~~ (3-15-22)()

~~15. Dietary Standards.~~ Each facility must have a full-service kitchen to meet the needs of the residents. Any satellite kitchen must meet all applicable requirements. (3-15-22)

251. --254. (RESERVED)

255. REQUIREMENTS FOR ADDITIONAL PHYSICAL STANDARDS.

01. Fire District. The facility site must be in a lawfully constituted fire district. (3-15-22)

02. Roads. The facility must be served by an all-weather road and kept open to motor vehicles at all times of the year. (3-15-22)

03. Medical Accessibility. The facility site must be accessible to authorized providers or emergency medical services within thirty (30) minutes driving time. (3-15-22)

256.-- 259. (RESERVED)

260. REQUIREMENTS FOR ENVIRONMENTAL SANITATION.

01. Water Supply. ~~The facility must have an adequate water supply that is safe and of a sanitary quality~~ Water supply must be from an approved private, public, or municipal water supply. (3-15-22)()

a. The water supply must be from an approved private, public, or municipal water supply; (3-15-22)

ba. Water from a private supply must have water samples submitted annually to either a private accredited laboratory or to the Public Health District Laboratory for bacteriological examination. The Department may require more frequent examinations if warranted; ~~and.~~ (3-15-22)(____)

~~e.~~ There must be a sufficient amount of water under adequate pressure to meet sanitary and fire sprinkler system requirements of the facility at all times. (3-15-22)

02. **Sewage Disposal.** All sewage and liquid waste must be discharged into a municipal sewage system where such a system is available. If a municipal sewage system is not available, sewage and liquid waste must be collected, treated, and disposed of in a manner approved by the Department. (3-15-22)

032. **Garbage and Refuse Disposal.** Garbage and refuse disposal must be provided to ensure that: (3-15-22)

a. The premises and all buildings must be kept free from the accumulation of weeds, trash, and rubbish; (3-15-22)

b. Material not directly related to the maintenance and operation of the facility must not be stored on the premises; ~~and~~ (3-15-22)(____)

~~e.~~ All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material, and must not leak. Containers must be provided with tight-fitting lids unless stored in a vermin-proof room or enclosure; ~~and~~ (3-15-22)

~~dc.~~ Garbage containers must be maintained in a sanitary manner. Sufficient containers must be afforded to hold all garbage and refuse which accumulates between periods of removal from the facility. ~~Storage areas must be clean and sanitary.~~ (3-15-22)(____)

043. **Insect and Rodent Control.** A pest control program must ~~be in effect at all times.~~ This program ~~must~~ effectively prevent insects, rodents, and other pests from entrance to, or infestation of, the facility. (3-15-22)(____)

054. **Linens and Laundry Facilities and Services.** (3-15-22)

a. The facility must have ~~available at all times a quantity of~~ linen ~~essential~~ suitable to the proper care and comfort of residents; ~~and~~ (3-15-22)(____)

b. ~~Linens must be of good quality, n~~Not thread-bare, torn, or stained; (3-15-22)(____)

c. ~~Linens must be h~~Handled, processed, and stored in an appropriate manner that prevents contamination; (3-15-22)(____)

~~d.~~ Adequate facilities must be provided for the proper and sanitary washing and drying of linen and other washable goods laundered in the facility; (3-15-22)

~~ed.~~ ~~The laundry must be s~~Situated in an area separate and apart from where food is stored, prepared, or served; (3-15-22)(____)

~~f.~~ The laundry area must be well-lighted, ventilated, adequate in size for the needs of the facility, maintained in a sanitary manner, and kept in good repair; (3-15-22)

~~ge.~~ ~~Care must be taken to ensure s~~Soiled linen and clothing ~~are~~ must be properly handled to prevent contamination. Clean linen and clothing received from a laundry service must be stored in a proper manner to prevent contamination; and (3-15-22)(____)

hf. Residents' and personnel's personal laundry must be collected, transported, sorted, washed, and dried in a sanitary manner and cannot be washed with general linens (e.g., towels and sheets). (3-15-22)

065. Housekeeping and Maintenance Services. Housekeeping, maintenance personnel, and equipment must be provided to maintain the interior and exterior of the facility in a clean, safe, and orderly manner. Prior to occupancy of any sleeping room by a new resident, the room must be thoroughly cleaned including the bed, bedding, and furnishings. (3-15-22)

076. Toxic Chemicals. All toxic chemicals must be properly labeled. Toxic chemicals cannot be stored where food is stored, prepared, or served, where medications are stored, and where residents with cognitive impairment have access. (3-15-22)

261. – 304. (RESERVED)

305. REQUIREMENTS FOR THE LICENSED-REGISTERED NURSING ASSESSMENT.

For each resident the licensed-~~registered~~ nurse must assess-~~and~~, document, ~~including~~ date and ~~signature~~ sign, the following: (3-15-22)()

~~01. Resident Medications and Therapies.~~ Each resident's use of, and response to all medications, (including over-the-counter, and prescribed therapies), the monitoring of side effects, interactions, abuse, or other adverse effects, and ensuring the resident's physician or authorized provider is notified of any identified concerns with medications and therapies. (3-15-22)

~~02. Current Medication Orders and Treatment Orders.~~ Each resident's medication and treatment orders are current and verified for the following: (3-15-22)

~~a. The medication listed on the medication distribution container, including over-the-counter medications, is consistent with physician or authorized provider orders; (3-15-22)~~

~~b. The physician or authorized provider orders related to therapeutic diets, treatments, and medications for each resident are followed; and (3-15-22)~~

~~c. A copy of the actual written, signed, and dated orders are present in each resident's care record. (3-15-22)~~

01. Pre-Admission Assessment. A review of the resident's health and medical status including identification of medical and care needs. ()

02. Quarterly Nursing Assessments. The facility nurse must visit the facility at least once every ninety (90) days to conduct quarterly assessments. The assessments must include: ()

a. Review of the residents' health and medical status, including any changes in medical or physical status; and ()

b. Recommendations for changes needed to the NSA to meet the residents' needs. ()

03. Change in Resident Health Status. ~~The health status of each resident by conducting a p~~ Physical assessment ~~and~~, identifying symptoms of illness, or ~~any~~ changes in mental or physical health status. (3-15-22)()

04. Recommendations. ~~Recommendations to~~ Notify the administrator regarding any ~~medication needs, other health needs requiring follow-up, or medical~~ changes ~~needed requiring amendments~~ to the NSA. ~~The nurse must notify~~ Notify the physician or authorized provider of ~~recommendations for medical care and services that are needed~~ medical changes. (3-15-22)()

05. Progress of Previous Recommendations. ~~The progress of previous recommendations regarding any medication needs or other health needs that require follow-up. (3-15-22)~~

065. Self-Administered Medication. ~~Each resident participating in a self-administered medication program at the following times:~~ Residents must be assessed prior to self-administering medications and every ninety

(90) days thereafter. (3-15-22)()

- a. Before the resident can self-administer medication to ensure resident safety; and (3-15-22)
- b. Every ninety (90) days to evaluate the continued validity of the assessment to ensure the resident is still capable to safely self-administer medication(s). (3-15-22)

07. Resident and Facility Staff Education. Recommendations for any health care-related educational needs, for both the resident and facility staff, as the result of the nursing assessment or at the direction of the resident's health care provider. (3-15-22)

306. -- 309. (RESERVED)

310. REQUIREMENTS FOR MEDICATIONS AND TREATMENTS.

Facility policies and procedures must specify how medications will be handled. (3-15-22)

01. Medication Distribution System. Each facility must use medi-sets or blister packs for prescription medications. The facility may use multi-dose medication distribution systems that are provided for resident's receiving medications from the Veterans Administration or Railroad benefits. The medication system must be filled by a pharmacist and appropriately labeled in accordance with pharmacy standards and physician or authorized provider instructions. The facility's licensed nurse may fill medi-sets, blister packs, or other Licensing Agency approved systems as described in Section 39-3326, Idaho Code. The facility must ensure. (3-15-22)()

- a. All medications must be kept in a locked area such as a locked box or room; (3-15-22)
- b. Poisons, toxic chemicals, and cleaning agents must not be stored with medications; (3-15-22)
- c. Biologicals and other medications requiring cold storage must be maintained at thirty-eight degrees Fahrenheit to forty-five degrees Fahrenheit (38°F-45°F); per manufacturer's guidelines and the temperature monitored and documented daily weekly; (3-15-22)()

d. Assistance with medication must comply with the Board of Nursing requirements; (3-15-22)

e. Each prescription medication must be given to the resident directly from the medi-set, blister pack, or medication container; (3-15-22)

f. Each resident must be observed taking the medication; and (3-15-22)

g. Medications and treatments must be provided per physician or authorized provider orders. ()

h. Each prescribed PRN must be available in the facility. (3-15-22)

02. Discontinued and Expired Prescriptions. Discontinued or outdated medications and treatments must be removed from the resident's medication supply and cannot accumulate at the facility for longer than thirty (30) days. The unused medication must be disposed of in a manner that ensures it cannot be retrieved properly. The facility may enter into agreement, a copy of which must be maintained, with a pharmacy or other authorized entity to return unused, unopened medications for proper disposition. A written record of all drug disposals must be maintained in the facility and include must document the following: (3-15-22)()

- a. A description of the drug, including the amount; (3-15-22)
- b. Name of the resident for whom the medication is prescribed; (3-15-22)
- c. The reason for method and date of disposal; and (3-15-22)()
- d. The method of disposal; (3-15-22)

- ~~e.~~ The date of disposal; and (3-15-22)
- ~~f.d.~~ Signatures of responsible facility personnel and witness. (3-15-22)
- 03. Controlled Substances.** The facility must track all controlled substances entering the facility, including the amount received, the date, a daily count, reconciliation of the number given or disposed, and the number remaining. (3-15-22)
- 04. ~~Psychotropic or~~ Behavior Modifying Medication.** (3-15-22)()
- a.** Psychotropic or behavior modifying medication intervention must not be the first resort to address behaviors. The facility must attempt non-drug interventions to assist and redirect the resident's behavior. (3-15-22)
- ~~b.~~ Psychotropic or behavior modifying medications must be prescribed by a physician or authorized provider. (3-15-22)
- ~~e.b.~~ The facility must ~~monitor the resident to determine continued need for the medication based on the resident's demonstrated behaviors~~ document residents' response to the medications including demonstrated behaviors and any side effects that impacted the residents' health or safety. (3-15-22)()
- ~~c.~~ The facility must provide behavior updates to the physician or authorized provider when requested. ()
- ~~d.~~ The facility must monitor the resident for any side effects that could impact the resident's health and safety. (3-15-22)
- ~~e.~~ The use of psychotropic or behavior modifying medications must be reviewed by the physician or authorized provider at least every six (6) months. The facility must provide behavior updates to the physician or authorized provider to help facilitate an informed decision on the continued use, and possible reduction, of the psychotropic or behavior modifying medication. (3-15-22)

311. -- 3189. (RESERVED)

349. COMPREHENSIVE ASSESSMENT REQUIREMENTS.

The facility must complete assessment information as described in Subsections 319.01 through 319.04 of this rule, prior to admitting the resident to the residential assisted living facility. The remainder of the comprehensive assessment must be completed within fourteen (14) days of admission. Comprehensive assessment information must be updated when there is a change, or at least every twelve (12) months. The comprehensive assessment must contain the following: (3-15-22)

- 01. Resident Demographics.** Resident demographic information, including: (3-15-22)
 - ~~a.~~ Date of birth; (3-15-22)
 - ~~b.~~ Placement history; (3-15-22)
 - ~~c.~~ Identification of any medical diagnoses, including any information about specific health problems, such as allergies, that may be useful in a medical emergency; (3-15-22)
 - ~~d.~~ Prescription and over-the-counter medications and treatments; (3-15-22)
 - ~~e.~~ Information related to cognitive function; (3-15-22)
 - ~~f.~~ Legal status, to include copies of legal documents when applicable (e.g., guardianship or power of attorney); and (3-15-22)
 - ~~g.~~ Names and contact information of representatives and emergency contacts. (3-15-22)

~~02. **Level of Personal Assistance Required.** The facility must assess the level of assistance required to help the resident with the following: Activities of daily living, including bathing, dressing, toileting, grooming, eating, communicating, medications, and the use of adaptive equipment, such as hearing aids, walkers, or eyeglasses. (3-15-22)~~

~~03. **Nursing Assessment.** Information related to the resident's health, medical status, and identification of any health services needed, including frequency and scope. (3-15-22)~~

~~04. **Maladaptive Behaviors.** Evaluation of maladaptive behaviors, including: (3-15-22)~~

~~a. The resident's behavioral history, including any history of traumatic events; (3-15-22)~~

~~b. The intensity, duration, and frequency of each maladaptive behavior; (3-15-22)~~

~~c. Potential contributing environmental factors, such as heat, noise, or overcrowding; (3-15-22)~~

~~d. Any specific events that can trigger maladaptive behaviors; (3-15-22)~~

~~e. Potential contributing health factors, such as hunger, pain, constipation, infection, fever, or medication side effects; and (3-15-22)~~

~~f. Recent changes in the resident's life, such as a death in the family or changes in care. (3-15-22)~~

~~05. **Resident Preferences.** Resident preferences and historical information that includes: (3-15-22)~~

~~a. Religion and church attendance, including preferred church contact information; (3-15-22)~~

~~b. Historical information including significant life events, family, work, and education; and (3-15-22)~~

~~c. Hobbies or preferred activities. (3-15-22)~~

~~06. **Outside Services.** Information related to outside services, including the service type being provided, when, and by whom. (3-15-22)~~

~~07. **Assessment Results.** The results of the comprehensive assessment must be used to develop the NSA, identify training needs for staff, and evaluate the ability of an administrator and facility to meet the identified resident's needs. (3-15-22)~~

320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.

~~Under Section 39-3309, Idaho Code, each resident must enter into an NSA completed, signed, and implemented no later than fourteen (14) calendar days from the date of admission. An interim plan must be developed and used while the NSA is being completed as described in Section 330 of these rules. (3-15-22)()~~

~~01. **Use of NSA.** The NSA provides for the coordination of services and instruction to the facility staff. Upon completion, the agreement must clearly identify the resident, describe services to be provided, the frequency of such services, and how such services are to be delivered. (3-15-22)~~

~~02. **Key Elements of the NSA.** A resident's NSA must be based on the comprehensive assessment information described in Section 319 of these rules. NSAs must incorporate information from the resident's care record, described in Section 330 of these rules. (3-15-22)~~

~~03. **Signature, Date, and Approval of Agreement.** The administrator, resident, and any legal representative must sign and date the NSA upon its completion. (3-15-22)~~

~~04. **Review Date.** The NSA must include the next scheduled date of review. (3-15-22)~~

~~05. Development of the NSA.~~ The resident, and other relevant persons as identified by the resident, must be included in the development of the NSA. Licensed and professional staff must be involved in the development of the NSA as applicable. (3-15-22)

~~06. Copy of Initial Agreement.~~ Signed copies of the agreement must be given to the resident, their representative, and their legal guardian or conservator, and a copy placed in the resident's record, no later than fourteen (14) calendar days from admission. (3-15-22)

~~07. Resident Choice.~~ A resident must be given the choice and control of how and what services the facility or external vendors will provide, to the extent the resident can make choices. The resident's choice must not violate the provisions of Section 39-3307(1), Idaho Code. (3-15-22)

~~08. Periodic Review.~~ The NSA must be reviewed when there is a change in a diagnosis for a resident or other change in condition requiring different, additional, or replacement services, or at least every twelve (12) months. (3-15-22)

321. -- 329. (RESERVED)

330. REQUIREMENTS FOR FACILITY RECORDS.

The facility must ~~maintain complete, accurate, and authentic records which are preserved in a safe location protected from fire, theft, and water damage~~ develop policies and procedures in accordance with Sections 39-3316, Idaho Code, for a minimum of three (3) years. (3-15-22)()

01. Paper Records. All paper records must be recorded legibly in ink. (3-15-22)

~~02. Electronic Records.~~ Electronic records policies and procedures must be developed and implemented that specify which records will be maintained electronically. Policy development and implementation must ensure: (3-15-22)

~~a.~~ The facility must print and provide paper copies of electronic records upon the request of the resident, their legal guardian or conservator, advocacy and protection agencies, and the Department. (3-15-22)

~~b.~~ Security measures must be taken to protect the use of an electronic signature by anyone other than the person to which the electronic signature belongs and to protect that person's identity. The policy must specify how passwords are assigned, and the frequency they are changed. (3-15-22)

~~c.~~ Security measures must be taken to ensure the integrity of any electronic documentation. (3-15-22)

~~032. Record Confidentiality.~~ The facility must ~~safeguard confidential information against loss, destruction, and unauthorized use~~ comply with the Health Insurance Portability and Accountability Act (HIPAA). (3-15-22)()

~~043. Resident Care Records.~~ An Each resident must have an individual care record must be maintained for each resident with all entries kept current. Entries must be documented during each shift and completed by the person providing the care, including the date, time, name, and title of the person making the entry. (3-15-22)()

~~a.~~ Entries must include the date, time, name, and title of the person making the entry. Staff must sign each entry made by them during their shift. (3-15-22)

~~ba.~~ Care records of all current residents The plan of care must be available to staff at all times: and include: (3-15-22)()

~~c.~~ In addition to an NSA, as described in Section 320 of these rules, each care record must include documentation of the following: (3-15-22)

~~i.~~ Comprehensive assessments, as described in Section 319 of these rules; (3-15-22)

- ~~ii.~~ Current medications, treatments, and diet prescribed, all signed and dated by the ordering physician or authorized provider. A copy of written, signed, and dated medication and treatment orders; (3-15-22)()
- ~~iii.~~ Treatments, wound care, assistance with medications, and any ~~other~~ delegated nursing tasks. Documentation must include any PRN medication use (if applicable), including the reason for taking the medication and the efficacy; (3-15-22)()
- ~~iv.~~ ~~ii.~~ Times the NSA is not followed, such as during refusal of care or services. This includes any time a medication is refused by a resident, not taken by a resident, not given to a resident, and the reason for the omission. Documentation when the resident refuses care or services or the resident missed taking prescribed medication including the reason; (3-15-22)()
- ~~v.~~ Calls to the resident's physician or authorized provider, including the reason for each call and the outcome; (3-15-22)
- ~~vi.~~ ~~iv.~~ Notification to the facility nurse of changes in the resident's physical or mental condition; (3-15-22)
- ~~vii.~~ Nursing assessments, ~~as described in Section 305 of these rules;~~ (3-15-22)()
- ~~viii.~~ The results of any physician or authorized provider visits, including phone calls to providers including the reason and outcome; (3-15-22)()
- ~~ix.~~ ~~vii.~~ Copies of all signed and dated care plans prepared by outside service agencies; (3-15-22)
- ~~x.~~ ~~viii.~~ Notes regarding outside services and care provided to the resident, such as home health, hospice, or physical therapy; (3-15-22)
- ~~xi.~~ ~~ix.~~ Unusual events such as incidents, accidents, or altercations, and the facility's response; and (3-15-22)
- ~~xii.~~ When a resident refuses medical treatment or physician's orders, the facility must document the resident and their legal guardian have been informed of the consequences of the refusal and the resident's physician or authorized provider has been notified of the refusal. Documentation the physician, authorized, and legal representative provider has been contacted when a resident consistently refuses medical treatment or physician orders. (3-15-22)()

~~05. Admission Records.~~ As described in Section 39-3315, Idaho Code, resident admission documentation must include: (3-15-22)

- ~~a.~~ The resident's preferred providers and contact information, including physician or authorized provider, optometrist, dentist, pharmacy, and outside service providers. (3-15-22)
- ~~b.~~ Results of the resident's last history and physical examination, performed by a physician or authorized provider. The examination must have been conducted no more than six (6) months prior to admission. (3-15-22)
- ~~c.~~ Physician or authorized provider orders that are current, signed, and dated, including a list of medications, treatments, diet, and any limitations. (3-15-22)
- ~~d.~~ A written admission agreement that is signed and dated by the administrator and the resident or their legal guardian or conservator, and meets the requirements of Section 216 of these rules. (3-15-22)
- ~~e.~~ If separate from the admission agreement, a copy of the payment schedule and fee structure signed and dated by the resident or their legal guardian or conservator. (3-15-22)
- ~~f.~~ If the facility manages the resident's funds, a signed and dated written agreement between the

facility and the resident or their legal guardian or conservator that specifies the terms. (3-15-22)

~~g. A signed copy of the resident's rights, as described in Sections 550 and 560 of these rules, or a signed and dated statement that the resident or their legal guardian or conservator has read and understands their rights in a residential assisted living facility. (3-15-22)~~

~~h. An interim care plan signed by the resident, responsible party, and the facility, completed prior to, or on the day of, admission. (3-15-22)~~

~~i. Documentation indicating the resident has been informed of the facility's emergency procedures, including resident responsibility. (3-15-22)~~

064. Behavior Documentation. For residents who exhibit maladaptive behaviors, ~~behavior management records must be maintained in the resident record, including~~ the facility must maintain documentation of the following: (3-15-22)()

a. An assessment of maladaptive behaviors, ~~as described in Section 319 of these rules.~~ (3-15-22)()

b. A behavior plan that includes ~~at least one (1) intervention specific to each maladaptive behavior;~~ s; (3-15-22)()

i. Interventions must be the least restrictive possible; and must include the date and time of each maladaptive behavior, a description of the behavior, the interventions implemented and the effectiveness of each intervention. (3-15-22)()

ii. ~~Each intervention must be reviewed as appropriate, based on the severity of the behavior, to evaluate the effectiveness and continued need for the intervention. (3-15-22)~~

~~e. Ongoing tracking of behaviors, including documentation of the date and time each maladaptive behavior was observed, the specific behavior that was observed, what interventions were used in response to the maladaptive behavior, and the effectiveness of each intervention. (3-15-22)~~

075. Discharge Records. Resident discharge documentation must include: (3-15-22)

a. ~~When the discharge is involuntary, the facility's efforts to resolve the situation and a copy of the discharge notice, signed and dated by the resident and the facility. If the resident refuses, or is unable to sign the notice, the facility must maintain evidence that the notice was delivered to the resident and the responsible party~~ A copy of the written notice of discharge if applicable; (3-15-22)()

b. The date and the location where the resident ~~is~~ was discharged; and (3-15-22)()

c. The disposition of the resident's belongings. (3-15-22)

086. Additional Resident Records. The facility must also maintain the following for each resident: (3-15-22)

a. A record of all resident personal property ~~that the resident has entrusted to the facility, including documentation to identify and track the property to ensure that personal items are kept safe and used only by the resident to which the items belong with a value of more than fifty dollars (\$50); and~~ (3-15-22)()

b. Any ~~A record of~~ complaints or grievances ~~voiced by the resident~~ including the date received, the investigation ~~with and the~~ outcome, ~~and the response to the resident.~~ (3-15-22)()

097. Resident Admission and Discharge Register. The facility must maintain an admission and discharge register listing the name of each resident, the date admitted, and the date discharged. ~~The admission and discharge register must be produced as a separate document, apart from resident records, and kept current.~~

(3-15-22)()

~~10. Hourly Adult Care Documentation.~~ A log of those who have utilized hourly adult care must be maintained, including the dates the service was provided. Individual records must be maintained for each person utilizing hourly adult care. The individual record documentation must include: (3-15-22)

~~a. Admission identification information, including contact information for the responsible party in an emergency, and the physician or authorized provider;~~ (3-15-22)

~~b. Information, such as medical and social, relevant to the supervision of the person; and~~ (3-15-22)

~~c. Care and services provided during hourly adult care, including assistance with medications.~~ (3-15-22)

~~11.08. Dietary Records.~~ The facility must maintain on-site a minimum of three (3) months of dietary documentation, as follows records including: (3-15-22)()

~~a. Copies of planned menus, including therapeutic menus, that are approved, signed, and dated by a dietitian; and~~ Planned, substitution, and therapeutic menus that have been approved and signed by a licensed registered dietitian. (3-15-22)()

~~b. Served menus, including therapeutic menus, which reflect substitutions made.~~ (3-15-22)

~~09. Water Supply.~~ Laboratory reports documenting the bacteriological examination of a private water supply. ()

~~12. Records for Water Supply.~~ Copies of laboratory reports documenting the bacteriological examination of a private water supply must be kept on file in the facility. (3-15-22)

~~13.0. Personnel Records.~~ A record for each employee must be maintained and available, which includes the following: (3-15-22)

~~a. The employee's name, address, phone number, and date of hire;~~ (3-15-22)

~~b. A job description that includes the purpose, responsibilities, duties, and authority;~~ (3-15-22)

~~c. Evidence that on, or prior to hire, staff were notified in writing if the facility does or does not carry professional liability insurance. If the facility cancels existing professional liability insurance, all staff must be notified of the change in writing;~~ (3-15-22)

~~dc. A copy of a current valid license for all nursing staff and verification from the Board of Nursing that the license is in good standing with identification of restrictions;~~ (3-15-22)()

~~ed. Signed evidence of training as described in Sections 620 through 641 of these rules and dated record of all required staff training;~~ (3-15-22)()

~~fe. Copies of CPR and first aid certifications;~~ (3-15-22)

~~gf. Evidence of medication training as described in Section 645 of these rules;~~ (3-15-22)()

~~hg. Criminal history and background check results that meet Section 009 of these rules and state-only background check results;~~ (3-15-22)()

~~ih. Documentation by the licensed nurse of delegation to unlicensed staff who assist residents with medications and other nursing tasks;~~ (3-15-22)()

~~ji. When acting on behalf of the administrator, a signed document authorizing the responsibility~~ A

~~signed and dated record identifying any administrator or manager designees;~~ and (3-15-22)()

~~kj.~~ Copies~~Records~~ of contracts with outside service providers and contract staff. (3-15-22)()

~~141.~~ **As Worked Schedules.** Work records ~~must be maintained in written or electronic format which reflect:~~ indicating direct care staff names and shifts worked. (3-15-22)()

~~a.~~ Personnel on duty, at any given time; and (3-15-22)

~~b.~~ The first and last names of each employee and their position. (3-15-22)

153. Fire and Life Safety Records. The administrator must ensure the facility's records for fire and life safety are maintained. The facility must maintain on file: (3-15-22)

~~a.~~ Fire~~The results of fire~~ detection, alarm, ~~and communication system reports inspections, maintenance, and test results including:~~ (3-15-22)()

i. The results of the annual inspection and tests; and (3-15-22)

ii. Smoke detector sensitivity testing results. (3-15-22)

~~b.~~ The results of any ~~weekly, monthly, quarterly, semi-annual, and annual~~ sprinkler system inspections, maintenance, and tests; (3-15-22)()

~~c.~~ Records of the mMonthly examination of ~~the~~ portable fire extinguishers, including initials and date and documenting the following: (3-15-22)()

~~i.~~ Each extinguisher is in its designated location; (3-15-22)

ii. Each extinguisher seal or tamper indicator is not broken; (3-15-22)

iii. Each extinguisher has not been physically damaged; (3-15-22)

~~iv.~~iii. Each extinguisher gauge shows a charged condition; and (3-15-22)

~~v.~~ The inspection tag or documentation for the extinguisher must show at least the initials of the person making the monthly examination and the date of the examination. (3-15-22)

~~d.~~ Documentation for when a fire watch is instituted and a fire watch log for each round of patrol, identifying who conducted the fire watch, date, time, and situations encountered. (3-15-22)

331. -- 334. (RESERVED)

335. REQUIREMENTS FOR INFECTION CONTROL.

~~The administrator is responsible for ensuring that~~ facility must develop policies and procedures consistent with recognized standards that control and prevent infections for both staff and residents ~~are developed and implemented throughout the facility, to include:~~ (3-15-22)()

01. Staff with an Infectious Disease. Staff with an infectious disease must not work until the infectious stage no longer exists or must be reassigned to a work area where contact with others is not expected and likelihood of transmission of infection is absent. (3-15-22)

02. Standard Precautions. Standard precautions for infection prevention must be ~~used in the care of residents to prevent transmission of infectious disease according to~~ in accordance with the Centers for Disease Control and Prevention (CDC) guidelines. ~~These guidelines may be accessed on the CDC website at http://www.cdc.gov/hai/.~~ (3-15-22)()

03. Reporting of Individual with an Infectious Disease. ~~The name of any resident or facility personnel with a reportable disease listed in Facilities must report any cases of resident or staff illness consistent with the diseases listed in IDAPA 16.02.10, "Idaho Reportable Diseases," must be reported immediately to the local health district authority with appropriate infection control procedures immediately implemented as directed by that local health authority. The facility must follow guidance from local health districts.~~ (3-15-22)()

336. -- ~~399~~**404. (RESERVED)**

~~400. REQUIREMENTS FOR FIRE AND LIFE SAFETY STANDARDS.~~

~~A facility's buildings must meet all requirements of the local and state codes that are applicable to residential assisted living facilities for fire and life safety standards. Facilities' evacuation capability is considered "impractical" as defined by NFPA, Standard 101.~~ (3-15-22)

~~401. FIRE AND LIFE SAFETY STANDARDS FOR NEW BUILDINGS HOUSING THREE THROUGH SIXTEEN RESIDENTS.~~

~~A newly constructed facility, change of ownership, or a building converted to a residential assisted living facility on or after January 1, 2021, housing three (3) to sixteen (16) residents on the first story only must comply with NFPA, Standard 101, Chapter 32, Small Facilities.~~ (3-15-22)

~~402. FIRE AND LIFE SAFETY STANDARDS FOR NEW BUILDINGS HOUSING SEVENTEEN OR MORE RESIDENTS AND MULTI-STORY BUILDINGS.~~

~~A newly constructed facility, change of ownership, or a building converted to a residential assisted living facility on or after January 1, 2021, housing seventeen (17) residents or more, or any building housing residents on stories other than the first story must comply with requirements of NFPA, Standard 101, Chapter 32, Large Facilities.~~ (3-15-22)

~~403. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR THREE THROUGH SIXTEEN RESIDENTS.~~

~~Existing facilities licensed prior to January 1, 2021, housing three (3) to sixteen (16) residents on the first story only, must comply with the requirements of the NFPA, Standard 101, Chapter 33, Small Facilities. Existing buildings that are not sprinklered may continue to operate, except when Section 401 of these rules apply.~~ (3-15-22)

~~404. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR SEVENTEEN OR MORE RESIDENTS AND MULTI-STORY BUILDINGS.~~

~~Existing facilities licensed prior to January 1, 2021 housing seventeen (17) or more residents and multi-story buildings or any building housing residents on stories other than the first story must comply with NFPA, Standard 101, Chapter 33, Large Facilities.~~ (3-15-22)

405. ADDITIONAL FIRE AND LIFE SAFETY STANDARDS FOR ALL BUILDINGS AND FACILITIES.

01. Electrical Installations and Equipment. Electrical installations and equipment must comply with applicable local or state electrical requirements in NFPA, Standard 101, Mandatory References. (3-15-22)

a. Extension cords and multi-plug adapters are prohibited; (3-15-22)

b. Relocatable Power Taps (RPTs) must be Underwriter Laboratories (U/L) approved with the following requirements: (3-15-22)

i. RPTs must be directly connected to a wall outlet; and (3-15-22)

ii. Have a built-in surge protector. (3-15-22)

02. Prohibited Applications. The following are prohibited uses of an RPT: (3-15-22)

a. Medical equipment; (3-15-22)

b. Daisy chain or plugging one (1) plug strip into a second plug strip; (3-15-22)

- ~~e. Appliances; (3-15-22)~~
- ~~d. As a convenience, in lieu of permanent installed receptacles; and (3-15-22)~~
- ~~e. Extend through walls, ceilings, floors, under doors or floor coverings, or be subject to environmental or physical damage. (3-15-22)~~

031. Medical Gases. Handling, use, and storage of medical gas must be according to ~~NFPA, Standard 99, Chapter 11, Performance, Maintenance, and Testing as referenced in Section 004 of these rules~~ local fire code standards. (3-15-22)()

04. ~~Fuel-Fired Heating.~~ ~~Fuel-fired heating devices and systems must be inspected, serviced, and cleaned at least annually by a person professionally engaged in the business of servicing these devices or systems. (3-15-22)~~

052. Natural or Man-Made Hazards. When natural or man-made hazards are present on the facility property or border the facility property, suitable fences, guards, railing, or a combination must be installed to provide protection for the residents. (3-15-22)

063. Telephone. The facility must have a telephone on the premises available for staff use in the event of an emergency. Emergency telephone numbers must be posted near the telephone. (3-15-22)

- 04. Prohibited Applications.** The following are prohibited uses of a Relocatable Power Tap. ()
- ~~a. Medical equipment; ()~~
 - ~~b. Daisy chain or plugging one (1) plug strip into a second plug strip; ()~~
 - ~~c. Appliances; ()~~
 - ~~d. As a convenience, in lieu of permanent installed receptacles; and ()~~
 - ~~e. Extend through walls, ceilings, floors, under doors or floor coverings, or be subject to environmental or physical damage. ()~~

406. -- 409. (RESERVED)

410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.

Fire drills must be conducted ~~not less than six (6) times a year on a bimonthly basis, with not less than two (2) conducted during the night when residents are sleeping. Records must be maintained on file at the facility and contain a description, date, and time of the drill, response of the personnel and residents, problems encountered, and recommendations for improvement quarterly and at least one per shift per year and include date and time of drill including personnel and residents involved.~~ (3-15-22)()

01. Report of Fire. ~~A separate report on each fire incident occurring within the facility must be submitted to the Licensing Agency~~ Any fire or fire incident occurring within the facility must be reported to the Department within thirty fifteen (3015) days of the occurrence. ~~The reporting form, "Facility Fire Incident Report," issued by the Licensing Agency is used to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries, if any.~~ A fire incident is considered any activation of the building's fire alarm system other than a false alarm, during testing of the fire alarm system, or during a fire drill. (3-15-22)()

02. Fire Watch. Where a required fire alarm system or fire sprinkler system is out of service for more than four (4) hours in a twenty-four (24) hour period, the ~~authority having~~ local jurisdiction must be notified, and the building evacuated, or an approved and documented fire watch provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. (3-15-22)()

411. -- 429. (RESERVED)

430. REQUIREMENTS FOR FURNISHINGS, EQUIPMENT, AND SUPPLIES, ~~AND BASIC SERVICES.~~

Each facility must provide ~~to the resident:~~ (3-15-22)()

01. Common Shared Furnishings. ~~Appropriately designed and constructed furnishings to meet the needs of each resident, including reading lamps, tables, comfortable chairs, or sofas. All items must be in good repair, clean, safe, and provided at no additional cost to the resident.~~ Common areas must be furnished with appropriate reading lamps, tables, chairs, or sofas that are clean, safe, and in good repair. (3-15-22)()

02. Resident Sleeping Room Furnishings. ~~Comfortable furnishings and individual storage, such as a dresser, for personal items for each resident in each sleeping room. All items~~ facility provided furnishings such as a dresser, or bed, must be in good repair, clean, and safe. Resident beds shall be at least thirty-six (36) inches wide. (3-15-22)()

03. Resident Bed. Each resident must be provided their own bed, which will be at least thirty-six (36) inches wide, substantially constructed, clean, and in good repair. Roll-away beds, cots, futons, folding beds, or double bunks are prohibited. Bed springs must be in good repair, clean, and comfortable. Bed mattresses must be standard for the bed, clean, and odor-free. A pillow must be provided. (3-15-22)

043. Resident Telephone Privacy. The facility must have at least one (1) telephone that is accessible to all residents, and provide local calls at no additional cost. The telephone must be placed in such a manner as to provide the resident privacy while using the telephone. (3-15-22)

054. Basic Services. ~~The following are basic services to be provided to the resident by the facility within the basic services rate:~~ Basic services and personal supplies must be provided in accordance with the admission agreement. (3-15-22)()

- ~~a.~~ Rent; (3-15-22)
- ~~b.~~ Utilities; (3-15-22)
- ~~c.~~ Food; (3-15-22)
- ~~d.~~ Activities of daily living services; (3-15-22)
- ~~e.~~ Supervision; (3-15-22)
- ~~f.~~ First aid; (3-15-22)
- ~~g.~~ Assistance with and monitoring of medications; (3-15-22)
- ~~h.~~ Laundering of linens owned by the facility; (3-15-22)
- ~~i.~~ Emergency interventions and coordination of outside services; (3-15-22)
- ~~j.~~ Routine housekeeping and maintenance of common areas; and (3-15-22)
- ~~k.~~ Access to basic television in common areas. (3-15-22)

06. Basic Supplies. The following are to be supplied by the facility at no additional cost to the resident: linens, towels, wash cloths, liquid hand soap, non-sterile exam gloves, toilet paper, and first aid supplies, unless the resident chooses to provide their own. (3-15-22)

07. Personal Supplies. Soap, shampoo, hair brush, comb, electric razor or other means of shaving, toothbrush, toothpaste, sanitary napkins, and incontinence supplies must be provided by the facility unless the

~~resident chooses to provide their own. The facility may charge the resident for personal supplies the facility provides and must itemize each item being charged to the resident.~~ (3-15-22)

~~08. **Resident Supplies and Furnishings.** If a resident chooses to provide their own supplies or furnishings, the facility must ensure that the resident's supplies or furnishings meet the minimum standards as identified in this rule.~~ (3-15-22)

431. -- 449. (RESERVED)

450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.

The facility food services must meet the standards in IDAPA 16.02.19, "Idaho Food Code," as incorporated in Section 004 of these rules. The facility must also implement operational policies for providing proper nutritional care for each resident, which includes procedures to follow if the resident refuses food or to follow a prescribed diet. (3-15-22)()

451. MENU AND DIET PLANNING.

The facility must provide each resident with at least the minimum food and nutritional needs in accordance with the Recommended Dietary Allowances established by the Food and Nutrition Board of the National Academy of Sciences. These recommendations are found in the Idaho Diet Manual incorporated by reference in Section 004 of these rules. The menu must be adjusted for age, sex, and activity as approved by a registered dietitian. (3-15-22)

~~01. **Menu.** The facility must have a menu~~ **Must be** planned or approved, and signed, and dated by a licensed registered dietitian prior to being served to any resident. The planned menu must meet nutritional standards. (3-15-22)()

~~a.~~ Menus will provide a sufficient variety of foods in adequate amounts at each meal; (3-15-22)

~~b.~~ Food selections must include foods that are served in the community and in season. Food selections and textures should account for residents' preferences, food habits, and physical abilities. (3-15-22)

~~c.~~ The current weekly menu must be posted in a facility common area; and (3-15-22)()

~~d.~~ The facility must serve the planned menu. If substitutions are made, the menu must be modified to reflect the substitutions. (3-15-22)

~~02. **Therapeutic Diets.** The facility must have a therapeutic diet menu~~ **Therapeutic menus must be** planned or approved, and signed, and dated by a licensed registered dietitian prior to being served to any resident. (3-15-22)()

~~a.~~ The therapeutic diet planned menu, if possible, must meet nutritional standards; (3-15-22)

~~b.~~ The therapeutic diet menu must be planned as close to a regular diet as possible; and (3-15-22)

~~c.~~ The facility must have for each resident on a therapeutic diet, an order from a physician or authorized provider. (3-15-22)

~~03. **Facilities Licensed for Sixteen Beds or Less.** In facilities licensed for sixteen (16) beds or less, menus must be planned in writing at least one (1) week in advance.~~ (3-15-22)

~~04. **Facilities Licensed for Seventeen Beds or More.** Facilities licensed for seventeen (17) beds or more must:~~ (3-15-22)

~~a.~~ Develop and implement a cycle menu which covers a minimum of two (2) seasons and is four (4) to five (5) weeks in length; (3-15-22)

~~b.~~ Follow standardized recipes; and (3-15-22)

- ~~e. Have available in the kitchen a current copy of the Idaho Food Code and Idaho Diet Manual. (3-15-22)~~

452. -- 454. (RESERVED)

455. FOOD SUPPLY.

The facility must maintain a seven (7) day supply of nonperishable foods and a two (2) day supply of perishable foods. The facility's kitchen must have the types and amounts of food to be served readily available to meet all planned menus during that time. (3-15-22)

456. -- 459. (RESERVED)

460. FOOD PREPARATION AND SERVICE.

01. Food Preparation. Foods must be prepared by methods that conserve nutritional value, flavor, and appearance. (3-15-22)

02. Frequency of Meals. ~~Food must be offered throughout the day, as follows:~~ Meals must be served at least three (3) times per day at regular intervals with snacks and fluids offered between meals. (3-15-22)()

~~a. To provide residents at least three (3) meals daily, at regular times comparable to normal mealtimes in the community; (3-15-22)~~

~~b. To ensure no more than fourteen (14) hours between a substantial evening meal and breakfast; (3-15-22)~~

~~c. Ensure that residents who are not in the facility for the noon meal are offered a substantial evening meal; and (3-15-22)~~

~~d. Offer snacks and fluids between meals and at bedtime. (3-15-22)~~

03. Food Preparation Area. Any areas used for food preparation must be maintained as follows: (3-15-22)

~~a. No live animals or fowl will be kept or maintained in the food service preparation or service area; and (3-15-22)~~

~~b. Food preparation and service areas cannot be used as living quarters for staff. (3-15-22)~~

043. Disposable Items. The facility will not use single-use items except in unusual circumstances for a short period of time or for special events. (3-15-22)

461. -- 509. (RESERVED)

510. REQUIREMENTS TO PROTECT RESIDENTS FROM ABUSE.

~~The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from abuse. These policies and procedures should be posted in a conspicuous place in the facility, shared with new residents, families upon admission, all residents annually thereafter, and made available upon request. (3-15-22)~~

511. -- 514. (RESERVED)

515. REQUIREMENTS TO PROTECT RESIDENTS FROM EXPLOITATION.

~~The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from exploitation. These policies and procedures should be posted in a conspicuous place in the facility, shared with new residents, families upon admission, all residents annually thereafter, and made available upon request. (3-15-22)~~

~~516. — 519. (RESERVED)~~

~~520. REQUIREMENTS TO PROTECT RESIDENTS FROM INADEQUATE CARE.~~

~~The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from inadequate care. These policies and procedures should be posted in a conspicuous place in the facility, shared with new residents, families upon admission, all residents annually thereafter, and made available upon request.~~ (3-15-22)

~~521. — 524. (RESERVED)~~

~~525. REQUIREMENTS TO PROTECT RESIDENTS FROM NEGLECT.~~

~~The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from neglect. These policies and procedures should be posted in a conspicuous place in the facility, shared with new residents, families upon admission, all residents annually thereafter, and made available upon request.~~ (3-15-22)

~~526. — 599. (RESERVED)~~

600. REQUIREMENTS FOR STAFFING STANDARDS.

The administrator ~~facility~~ must develop and implement written staffing policies and procedures based on the number of residents, resident needs, and configuration of the facility, for staffing to ensure adequate care is provided to residents which include: (3-15-22)()

01. On-Duty Staff Up and Awake During Residents' Sleeping Hours. ~~Qualified and trained s~~Staff must be up and awake, and immediately available in the facility during resident sleeping hours. (3-15-22)()

02. Detached Buildings or Units. Facilities with ~~residents housed in~~ detached buildings or units must have at least one (1) staff present and available in each building ~~or unit when residents are present in the building or unit. The facility must also ensure that each building or unit complies with the requirements for on-duty staff during resident sleeping hours to be up, awake, and immediately available in accordance with the facility's licensed bed capacity as provided in this rule. The Licensing Agency will consider a variance based on the facility's written submitted plan of operation~~ when residents are present. (3-15-22)()

03. Personnel Management. The administrator is responsible for the management of all personnel to include contract personnel. (3-15-22)

04. Sufficient Personnel. As described in Section 39-3322, Idaho Code, the facility will employ and the administrator will schedule sufficient personnel to: (3-15-22)

a. ~~Provide care and supervision, during all hours, as required in each resident's NSA, to ensure residents' health, safety, and comfort, and to ensure the interior and exterior of the facility is maintained in a safe and clean manner; and~~ (3-15-22)

b. ~~To provide for at least one (1) direct care staff with certification in first aid and cardio-pulmonary resuscitation (CPR) in the facility at all times. Facilities with multiple buildings or units will have at least one (1) direct care staff with certification in first aid and CPR in each building or each unit at all times.~~ (3-15-22)

03. Cardio-Pulmonary Resuscitation (CPR) and First Aid Certification. Provide for at least one (1) direct care staff with certification in first aid and CPR in the facility at all times. Facilities with multiple buildings or units will have at least one (1) direct care staff with certification in first aid and CPR in each building or each unit at all times. ()

~~601. — 619. (RESERVED)~~

~~620. REQUIREMENTS FOR TRAINING OF FACILITY PERSONNEL.~~

~~The facility must follow structured, written training programs designed to meet the training needs of personnel in~~

relation to responsibilities, as specified in the written job description, to provide for quality of care and compliance with these rules. Signed evidence of personnel training, indicating hours and topic, must be retained at the facility. (3-15-22)

~~621.~~ 624. (RESERVED)

625. ORIENTATION TRAINING REQUIREMENTS.

~~The administrator must ensure that each staff member~~ Staff must complete orientation training specific to their job description as described in Section 39-3324, Idaho Code. ~~Staff who have not completed the orientation training requirements must work with a staff who has completed the orientation training, within thirty (30) days of hire. Prior to working alone staff must have completed the orientation training requirements.~~ (3-15-22)()

01. Number of Hours of Training. A minimum of sixteen (16) hours of job-related orientation training must be ~~provided to all new personnel before they are allowed to provide~~ completed prior to providing unsupervised personal assistance to residents. The means and methods of training are at the facility's discretion. (3-15-22)()

~~02. Timeline for Completion of Training.~~ All orientation training must be completed within thirty (30) days of hire. (3-15-22)

032. Content for Training. Orientation training must include the following: (3-15-22)

a. The philosophy of residential assisted living and how it guides caregiving; (3-15-22)

ba. Resident rights; (3-15-22)

c. Cultural awareness; (3-15-22)

d. Providing personal assistance; (3-15-22)

e. How to respond to emergencies; (3-15-22)

~~fb.~~ Reporting and documentation requirements for ~~resident care records, incidents, accidents, complaints, and~~ allegations of abuse, neglect, and exploitation; (3-15-22)()

g. Identifying and reporting changes in residents' health or mental condition; (3-15-22)

h. Advance directives and do not resuscitate (DNR) orders; (3-15-22)

ic. Relevant policies and procedures; and (3-15-22)()

j. The role of the NSA; and (3-15-22)

~~k.~~ All staff employed by the facility, including housekeeping personnel and contract personnel, must be trained in infection control procedures for universal precautions. (3-15-22)

d. Training must be specific and appropriate to the population served. ()

626. --~~629.~~ (RESERVED)

~~630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY.~~

~~A facility admitting and retaining residents with a diagnosis of dementia, mental illness, developmental disability, or traumatic brain injury must train all staff to meet the specialized needs of these residents. Staff must receive specialized training within thirty (30) days of hire or of admission of a resident with one (1) of these conditions. The means and methods of training are at the facility's discretion. The training should address the following areas:~~

		(3-15-22)
01.	Dementia:	(3-15-22)
a.	Overview of dementia;	(3-15-22)
b.	Symptoms and behaviors of people with memory impairment;	(3-15-22)
c.	Communication with people with memory impairment;	(3-15-22)
d.	Resident's adjustment to the new living environment;	(3-15-22)
e.	Behavior management, including the consistent implementation of behavior interventions;	(3-15-22)
f.	Activities of daily living; and	(3-15-22)
g.	Stress reduction for facility personnel and the resident.	(3-15-22)
02.	Mental Illness:	(3-15-22)
a.	Overview of mental illnesses;	(3-15-22)
b.	Symptoms and behaviors specific to mental illness;	(3-15-22)
c.	Resident's adjustment to the new living environment;	(3-15-22)
d.	Behavior management, including the consistent implementation of behavior interventions;	(3-15-22)
e.	Communication;	(3-15-22)
f.	Activities of daily living;	(3-15-22)
g.	Integration with rehabilitation services; and	(3-15-22)
h.	Stress reduction for facility personnel and the resident.	(3-15-22)
03.	Developmental Disability:	(3-15-22)
a.	Overview of developmental disabilities;	(3-15-22)
b.	Interaction and acceptance;	(3-15-22)
c.	Promotion of independence;	(3-15-22)
d.	Communication;	(3-15-22)
e.	Behavior management, including the consistent implementation of behavior interventions;	(3-15-22)
f.	Assistance with adaptive equipment;	(3-15-22)
g.	Integration with rehabilitation services;	(3-15-22)
h.	Activities of daily living; and	(3-15-22)

- ~~i.~~ Community integration. (3-15-22)
- ~~04. Traumatic Brain Injury:~~ (3-15-22)
- ~~a.~~ Overview of traumatic brain injuries; (3-15-22)
- ~~b.~~ Symptoms and behaviors specific to traumatic brain injury; (3-15-22)
- ~~c.~~ Adjustment to the new living environment; (3-15-22)
- ~~d.~~ Behavior management, including the consistent implementation of behavior interventions; (3-15-22)
- ~~e.~~ Communication; (3-15-22)
- ~~f.~~ Integration with rehabilitation services; (3-15-22)
- ~~g.~~ Activities of daily living; (3-15-22)
- ~~h.~~ Assistance with adaptive equipment; and (3-15-22)
- ~~i.~~ Stress reduction for facility personnel and the resident. (3-15-22)

~~631. --~~ 639. (RESERVED)

640. CONTINUED TRAINING REQUIREMENTS.

Each employee must receive a minimum of eight (8) hours of job-related continued training per year. (3-15-22)

641. ADDITIONAL TRAINING RELATED TO CHANGES.

When policies or procedures are added, modified, or deleted, the date of the change must be specified on the policy and staff training must receive additional training related to the changes be updated. (3-15-22)()

642. -- 644. (RESERVED)

645. ASSISTANCE WITH MEDICATIONS.

~~01. Training Requirements. To provide assistance with medications, staff must have the following training requirements, and be delegated as described in this rule. Prior to assisting residents with medications, staff must complete the following:~~ (3-15-22)()

~~a. Before staff can begin assisting residents with medications, successful completion of a medication assistance course offered by one (1) of Idaho's community colleges. This training is not included as part of the minimum of sixteen (16) hours of orientation training or minimum of eight (8) hours of continued training per year or a curriculum approved by the Department. This training is in addition to the curriculum minimum orientation requirements.~~ (3-15-22)()

~~b. Staff training on documentation requirements and how to respond when a resident refuses or misses a medication, receives an incorrect medication, or when medication is unavailable or missing.~~ (3-15-22)

~~02. Delegation. The facility nurse must delegate and document assistance with medications and other nursing tasks. Each medication assistant must be delegated individually, including skill demonstration, prior to assisting with medications or nursing tasks, and any time the licensed nurse changes.~~ (3-15-22)

646. -- 899. (RESERVED)

900. ENFORCEMENT ACTIONS.

Enforcement actions, as described in ~~Sections 901 through 940 of~~ these rules and Sections 39-3357 and 39-3358,

Idaho Code, are actions the Department can impose upon a facility. The Department will consider a facility's compliance history, ~~change(s) of ownership~~, and the number, scope, and severity of the deficiencies when initiating or extending an enforcement action. The Department can impose any of the enforcement actions, independently or in conjunction with others. (3-15-22)()

901. ENFORCEMENT ACTION ~~OF SUMMARY SUSPENSION.~~

~~When the Department finds that the facility's deficient practice(s) immediately place the health or safety of any residents in danger, the Department may take immediate action through summary suspension of the facility's license, the imposition of temporary management, a limit on admissions, and transfer the residents.~~ If the Department determined non-compliance with these rules immediately jeopardizes the health or safety of residents the Department may take action in accordance with Section 39-3358, Idaho Code. (3-15-22)()

902. -- 909. (RESERVED)

910. ENFORCEMENT ACTION OF A CONSULTANT.

A consultant may be required when an acceptable plan of correction has not been submitted, ~~as described in Section 130 of these rules~~, or if the Department identifies repeat deficient practice(s) in the facility. The consultant is required to submit periodic reports to the Licensing Agency. (3-15-22)()

911. -- 919. (RESERVED)

920. ENFORCEMENT ACTION OF LIMIT ON ADMISSIONS.

01. Reasons for Limit on Admissions. The Department may limit admissions for the following reasons: (3-15-22)

a. The facility is inadequately staffed or the staff is inadequately trained to handle more residents; (3-15-22)

b. The facility otherwise lacks the resources necessary to support the needs of more residents; (3-15-22)

c. The Department identifies repeat core issues during any follow-up survey; ~~and or~~ (3-15-22)()

d. An acceptable plan of correction is not submitted as described in Section ~~130 of these rules~~ 39-3352, Idaho Code. (3-15-22)()

02. Notification of Limit on Admissions. ~~The Department will notify the facility of the limit on admissions of residents (e.g., a full ban of admissions, a limit of admissions based on resident diagnosis, etc.) pending the correction of deficient practice(s). Limits~~ or bans ~~on admissions to the facility will~~ remain in effect until the Department determines the facility has achieved full substantial compliance with requirements or receives written evidence and statements from the outside consultant that the facility is in compliance. (3-15-22)()

921. -- 924. (RESERVED)

925. ENFORCEMENT ACTION OF CIVIL MONETARY PENALTIES.

~~**01. Civil Monetary Penalties.** May be issued when a facility is operating without a license, repeat deficiencies are identified, or the facility fails to comply with conditions of the provisional license. Actual harm to a resident or residents does not need to be shown. A single act, omission, or incident will not give rise to imposition of multiple penalties, even though such act, omission, or incident may violate more than one (1) rule.~~ (3-15-22)

01. Civil Monetary Penalties. May be imposed when it is determined a facility is operating without a license, has repeat non-core deficiencies that place residents at significant risk for potential harm, or the facility fails to comply with conditions of the provisional license. Actual harm to a resident or residents does not need to occur. A single act, omission, or incident will not give rise to imposition of multiple penalties, even though such act, omission, or incident may violate more than one (1) rule. ()

02. **Assessment Amount for Civil Monetary Penalty.** ~~When a~~ Civil monetary penalties are imposed, such penalties are assessed at ten dollars (\$10) for each day the facility is or was out of compliance. ~~The amounts below are per deficiency, multiplied by the total number of occupied licensed beds according to the records of the Department at the time non-compliance is established.~~ (3-15-22)()

a. Repeat deficiency is ten dollars (\$10). Example below:

Number of Occupied Beds in Facility	Repeat Deficiency	Times Number of Days Out of Compliance	Amount of Penalty
44	\$10.00	30 days	\$3,300

(3-15-22)

b. In any ninety (90) day period, the penalty amounts may not exceed the limits shown in the following table:

Limits on Accruing Civil Monetary Amount	
Number of Occupied Beds in Facility	Repeat Deficiency
3-4 Beds	\$2,880
5-50 Beds	\$6,400
51-100 Beds	\$10,800
101-150 Beds	\$17,600
151 or More Beds	\$29,200

(3-15-22)

03. **Notice of Civil Monetary Penalties and Appeal Rights.** The Department will give written notice informing the facility of the amount of the penalty, the basis for its assessment and the facility's appeal rights. (3-15-22)

04. **Payment of Penalties.** The facility must pay the full amount of the penalty within thirty (30) calendar days from the date the notice is received, unless the facility requests an administrative review of the decision to assess the penalty. The amount of a civil monetary penalty determined through administrative review must be paid within thirty (30) calendar days of the facility's receipt of the dated administrative review decision, unless the facility requests an administrative hearing. The amount of the civil monetary penalty determined through an administrative hearing must be paid within thirty (30) calendar days of the facility's receipt of the administrative dated hearing decision unless the facility files a petition for judicial review. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Such interest accrual will begin one (1) calendar day after the date of the initial assessment of the penalty. (3-15-22)()

05. **Failure to Pay.** Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license or the amount will be withheld from Medicaid payments to the facility. (3-15-22)

926. -- 929. (RESERVED)

930. **ENFORCEMENT ACTION OF TEMPORARY MANAGEMENT.**

01. **Need for Temporary Management.** The Department may impose, and appoint the action of use of temporary management in situations where there is a need to oversee operation of the facility and to ensure the health and safety of the facility's residents it is determined there is immediate jeopardy to the health and safety of the

residents, such as:

(3-15-22)()

a. During an orderly transfer of residents of the facility to other facilities To ensure the safe relocation of residents due to a facility closure; or (3-15-22)()

b. A temporary manager is necessary to bring the facility back into substantial compliance Pending improvements to bring the facility into compliance with program requirements. (3-15-22)()

02. Notice of Temporary Management. The Department will give written notice to the facility of the imposition of temporary management. (3-15-22)

03. Who May Serve as a Temporary Manager. The Department may appoint any person or organization that meets the following qualifications: (3-15-22)

a. The temporary manager must not have any financial interest in the facility to be managed; (3-15-22)

b. The temporary manager must not be related, within the first degree of kinship, to the facility's owner, manager, administrator, or other management principal; (3-15-22)

c. The temporary manager must possess sufficient training, expertise, and experience in the operation of a facility as would be necessary to achieve the objectives of temporary management. If the temporary manager is to serve in a facility, the manager must possess an Residential Assisted Living Administrator's license; and (3-15-22)

d. The temporary manager must not be an existing competitor of the facility who would gain an unfair competitive advantage by being appointed as temporary manager of the facility. (3-15-22)

042. Powers and Duties of the Temporary Manager. The temporary manager ~~has the authority to direct and oversee the management, and to hire and discharge any consultant or personnel, including the administrator of the facility. The temporary manager has the authority to direct the expenditure of the revenues of the facility in a reasonable and prudent manner, to oversee the continuation of the business and the care of the residents, to oversee and direct those acts necessary to accomplish the goals of the program requirements, and to direct and oversee regular accounting. When the facility fails or refuses to carry out the directions of the temporary manager, the Department may revoke the facility's license~~ will have the authority to direct and oversee the day-to-day operations of the facility including the enforcement of policies and procedures and ensuring the facility is in compliance with these rules. (7-1-24)()

a. The temporary manager must observe the confidentiality of the operating policies, procedures, employment practices, financial information, and all similar business information of the facility, except that the temporary manager must make reports to the Department; (3-15-22)

b. The temporary manager may be liable for gross, willful or wanton negligence, intentional acts or omissions, unexplained shortfalls in the facility's fund, and breaches of fiduciary duty; (3-15-22)

c. The temporary manager ~~does not have authority to cause or direct the facility, its owner, or administrator to incur debt, unless to bring the facility into compliance with these rules, or to enter into any contract with a duration beyond the term of the temporary management of the facility;~~ (3-15-22)

d. The temporary manager ~~does not have authority to incur, without the permission of the owner, administrator, or the Department, capital expenditures in excess of two thousand dollars (\$2,000), unless the capital expenditures are directly related to correcting the identified deficiencies;~~ (3-15-22)

e. The temporary manager ~~does not have authority to cause or direct the facility to encumber its assets or receivables;~~ (3-15-22)

f. The temporary manager ~~does not have authority to cause or direct a facility, which holds liability or casualty insurance coverage, to cancel or reduce its liability or casualty insurance coverage; and~~ (3-15-22)

~~g. The temporary manager does not have authority to cause or direct the sale of the facility, its assets or the premises on which it is located. (3-15-22)~~

053. Responsibility for Payment of the Temporary Manager. All compensation and per diem costs of the temporary manager must be paid by the licensee. (3-15-22)

~~**06. Termination of Temporary Management.** A temporary manager may be replaced under the following conditions: (3-15-22)~~

~~a. The Department may require replacement of any temporary manager whose performance is deemed unsatisfactory by the Department. No formal procedure is required for such removal or replacement, but written notice of any action will be given to the facility. (3-15-22)~~

~~b. A facility subject to temporary management may petition the Department for replacement of a temporary manager whose performance it considers unsatisfactory. The petition must include why the replacement of a temporary manager is necessary or appropriate. (3-15-22)~~

931. -- 934. (RESERVED)

935. ENFORCEMENT ACTION OF A PROVISIONAL LICENSE.

A provisional license may be issued when a facility has one (1) or more core issues, when non-core issues have not been corrected, have become repeat deficiencies, or an acceptable plan of correction is not submitted as described in these rules. The provisional license will state the conditions the facility must follow to continue to operate. (3-15-22)

936. --939. (RESERVED)

~~**940. ENFORCEMENT ACTION OF REVOCATION OF FACILITY LICENSE.**~~

~~**01. Revocation of Facility's License.** The Department may revoke a license when the facility endangers the health or safety of residents, or when the facility is not in substantial compliance with the provisions of Title 39, Chapter 33, Idaho Code, or this chapter of rules. (3-15-22)~~

~~**02. Reasons for Revocation or Denial of a Facility License.** The Department may revoke or deny any facility license for any of the following reasons: (3-15-22)~~

~~a. The licensee has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license; (3-15-22)~~

~~b. When persuaded by a preponderance of the evidence that such conditions exist which endanger the health or safety of any resident; (3-15-22)~~

~~c. Any act adversely affecting the welfare of residents is being permitted, aided, performed, or abetted by the person or persons in charge of the facility. Such acts may include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, criminal activity, or exploitation; (3-15-22)~~

~~d. The licensee has demonstrated or exhibited a lack of sound judgment essential to the operation and management of a facility; (3-15-22)~~

~~e. The licensee has violated any of the conditions of a provisional license; (3-15-22)~~

~~f. The facility lacks adequate personnel, as required by these rules or as directed by the Department, to properly care for the number and type of residents residing at the facility; (3-15-22)~~

~~g. Licensee refuses to allow the Department or the protection and advocacy agencies full access to the facility environment, facility records, and the residents as described in Sections 130 and 550 of these rules; (3-15-22)~~

- ~~h:~~ The licensee has been guilty of fraud, gross negligence, abuse, assault, battery, or exploitation with respect to the operation of a health facility, residential assisted living facility, or certified family home; (3-15-22)
- ~~i:~~ The licensee is actively affected in their performance by alcohol or the use of drugs classified as controlled substances; (3-15-22)
- ~~j:~~ The licensee has been convicted of a criminal offense other than a minor traffic violation within the past five (5) years; (3-15-22)
- ~~k:~~ The licensee is of poor moral and responsible character or has been convicted of a felony or defrauding the government; (3-15-22)
- ~~l:~~ The licensee has been denied, or the licensee's wrong-doing has caused the revocation of any license or certificate of any health facility, residential assisted living facility, or certified family home; (3-15-22)
- ~~m:~~ The licensee has previously operated any health facility or residential assisted living facility without a license or certified family home without a certificate; (3-15-22)
- ~~n:~~ The licensee is directly under the control or influence of any person who has been the subject of proceedings as described in this rule; (3-15-22)
- ~~o:~~ The licensee is directly under the control or influence of any person who is of poor moral and responsible character or has been convicted of a felony or defrauding the government; (3-15-22)
- ~~p:~~ The licensee is directly under the control or influence of any person who has been convicted of a criminal offense other than a minor traffic violation in the past five (5) years; (3-15-22)
- ~~q:~~ The licensee fails to pay civil monetary penalties imposed by the Department as described in Section 925 of these rules; (3-15-22)
- ~~r:~~ The licensee fails to take sufficient corrective action as described in Section 130 of these rules; or (3-15-22)
- ~~s:~~ The number of residents currently in the facility exceeds the number of residents the facility is licensed to serve. (3-15-22)

~~941.~~ 999. (RESERVED)

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

[LINK: LSO Rules Analysis Memo](#)

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

**THE FOLLOWING NOTICE PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is July 1st, 2025.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), and 56-265, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Monday, June 9, 2025 11:00 AM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=mfb6f2909a7d17e7447618fe97f63eac7
Join by meeting number Meeting number (access code): 2822 338 6614 Meeting password: 26Fi2shtJsu Meeting password when dialing from a phone or video system: 26342748
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)
Friday, June 20, 2025 1:00 PM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m8dde786d6ef5bc0caca430062852921f
Join by meeting number Meeting number (access code): 2828 200 3736 Meeting password: 9DJvRvv8MX9 Meeting password when dialing from a phone or video system: 93587888
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)

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

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

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 rule changes are intended to perform a comprehensive review and consolidation of existing chapters to streamline or simplify this rule language. IDAPA 16.03.09 and 16.03.10 were two of several rule chapters eliminated in House Bill 345 during the 2025 Idaho Legislative Session, which is set to take effect July 1st, 2025. The Department has combined components of both 16.03.09, Medicaid Basic Plan Benefits, and 16.03.10, Medicaid Enhanced Plan Benefits, into a single document which is proposed to be entitled 16.03.26 Medicaid Plan Benefits and take effect the same day the existing rules were set to expire.

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

House Bill 345 of the 2025 Idaho Legislative Session overwhelmingly passed both chambers of the state legislature and was signed by the governor. The final provisions of this bill eliminated several chapters of administrative rule related to Medicaid including both 16.03.09 and 16.03.10. It was made clear to both legislators and stakeholders that if this bill became law, that the Department would stand back up portions of the effected rules via temporary rule by July 1st, 2025.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted on 16.03.10 which has been folded into this temporary and proposed combined document. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 23 and 24](#).

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 Jared Larsen at DHWRules@dhw.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 June 25th, 2025.

DATED this 2nd day of May, 2025.

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

Italicized red text indicates amendments to the proposed text as adopted in the pending rule.

16.03.26 – MEDICAID PLAN BENEFITS

000. LEGAL AUTHORITY.

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

()

001. SCOPE.

These rules contain the general provisions regarding the administration of Medicaid. All goods and services not specifically included in this chapter are excluded from coverage under Medicaid Benefit Plans. These rules also contain requirements for provider procurement and reimbursement. Individuals eligible for the Medicaid Enhanced Plan, including those enrolled in a duals managed care plan, also receive all Medicaid Basic Plan benefits.

()

002. INCORPORATION BY REFERENCE.

01. Estimated Useful Lives of Depreciable Hospital Assets, 2023 Revised Edition. The document may be obtained from the American Hospital Association, 155 North Wacker Drive, Ste. 400, Chicago, IL, 60606.

()

02. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html>.

()

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. ()

008. – 009. (RESERVED)

GENERAL PARTICIPANT PROVISIONS
(Sections 010-019)

010. MEDICAL ASSISTANCE PROCEDURES.

The Department will issue a card to eligible participants which will contain their name and Medicaid identification number. When requested, the Department will give providers eligibility information regarding participants. ()

011. CHOICE OF PROVIDERS.

Participants may obtain services available from any participating provider of their choice, unless enrolled in a Managed Care Organization, Prepaid Ambulatory Health Plan, or Prepaid Inpatient Health Plan that limits provider choice, or a lock-in program. This does not prohibit the Department from setting standards relating to the qualifications of providers. ()

012. PARTICIPANT RESPONSIBILITY.

Participants are responsible for keeping appointments with providers. The Department will not reimburse providers when participants do not attend appointments. Providers cannot bill participants for missed appointments. ()

013. – 019. (RESERVED)

GENERAL PROVIDER PROVISIONS
(Sections 020-039)

020. INDIVIDUAL PROVIDER REQUIREMENTS.

01. Provider Eligibility. Be licensed or registered as required by the applicable jurisdiction for the profession, have a National Provider Identification (NPI) or Medicaid provider number, and enter into a written provider agreement with the Department. ()

02. Practice Authority. Provide services within the practice authority for the applicable profession consistent with the laws and regulations of the state where services are provided. ()

03. Standard of Care. Provide services within the accepted standard of care that would be provided in the same or similar setting by a reasonable and prudent provider with similar education, training, and experience as determined by the applicable oversight authority. ()

04. Express Exclusions. Not perform any service that is expressly prohibited by state or federal regulations. Further, no reimbursement will be provided for any service that is expressly excluded for a provider in these rules. ()

021. PROVIDER APPLICATION PROCESS.

01. Application. Providers who meet Medicaid enrollment requirements may apply for provider status with the Department. All providers eligible for an NPI must apply with that number. For providers not eligible for an NPI, the Department will assign a provider number upon approval of the application. ()

02. Disclosure of Information. All enrolling providers and any additional disclosable party must comply with the disclosure requirements in 42 CFR Part 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents." ()

03. Denial of Provider Agreement. The Department may refuse a request to enter into a provider agreement, extend an existing agreement, or enter into additional agreements with any provider. Requests for a provider agreement are denied when: ()

a. The provider fails to meet the qualifications required by rule or by any applicable licensing board. ()

b. The provider was a managing employee, or had an ownership interest, in any entity and: ()

i. Previously found by the Department to have engaged in fraudulent or abusive conduct related to the Medicaid program; or ()

ii. Demonstrated an inability to comply with the requirements related to the provider status for which application is made, including submitting false claims or violating provisions of any provider agreement; ()

c. Failed to repay the Department for any overpayments or improper claims, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law. ()

d. The provider employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in this section. ()

e. The provider is currently suspended or terminated from Medicare or Medicaid in any state. ()

022. PROVIDER AGREEMENTS.

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

01. General. All individuals or entities must enter into a written provider agreement accepted by the Department prior to receipt of any reimbursement for services. Agreements may contain any terms or conditions deemed appropriate by the Department. All provider agreements must be signed by an authorized representative who has the legal authority to bind the provider in the agreement. ()

02. Enforcement Actions and Terminations. The Department may take any of the following actions for cause based on the conduct of the provider, or its employees or agents, or when the provider fails to comply with the provider agreement, or any applicable state or federal regulation: ()

a. Require corrective actions in IDAPA 16.05.07; ()

b. Require a corrective action plan to be submitted by the provider to address noncompliance with requirements; ()

c. Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; ()

d. Limit or suspend provision of services to participants who have not previously established services with the provider pending the submission, acceptance, or completion of a corrective action plan; or ()

e. Terminate the provider's agreement. ()

i. The Department may terminate provider agreements with or without cause by giving written notice to the provider as set forth in the agreement. ()

ii. Terminations without cause may result from elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers or will result from the discretionary act of another regulatory body. If an agreement does not provide a notice period, the period is twenty-eight (28) days. ()

iii. Terminations for cause may be appealed. ()

03. Crossover Only Providers. Providers of professional services may enroll as crossover only providers that bill for dual eligible participants' Medicare coinsurance and deductible. Crossover only providers act as non-billing ORPs for all other participants. ()

04. Non-billing Ordering, Referring, and Prescribing (ORP). Providers may enroll as non-billing ORPs, provided they follow the provider application process and sign a provider agreement. Non-billing ORPs are not eligible for reimbursement and are otherwise not Medicaid providers. ()

023. – 024. (RESERVED)

025. CONDITIONS FOR PAYMENT.

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

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. ()

026. THIRD-PARTY LIABILITY.

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

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

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

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

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third-party payment, with the following exceptions: ()

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

b. Preventive pediatric care including early and periodic screening, diagnostic, and treatment services which includes: ()

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

ii. Diagnosis services to identify the nature of an illness or other problem by examination of the symptoms. ()

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

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

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

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

a. The provider's actual charge for the service; ()

b. The maximum allowable charge for the service as established by the Department in its pricing file; ()
or

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

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

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

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

09. Subrogation of Legal Fees. ()

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

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

027. – 029. (RESERVED)

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. ()

031. HANDLING OF OVERPAYMENTS AND UNDERPAYMENTS FOR SPECIFIED PROVIDERS.

This section of rule applies only to providers that are retrospectively cost settled. ()

01. Interest Charges. Medicaid charges interest on overpayments, and pays interest on underpayments, as follows: ()

a. If full repayment from an indebted party is not received within sixty (60) days after the provider received the Department reimbursement notice, interest accrues from the receipt date and is charged on any unpaid settlement balance for each thirty (30)-day period of delayed payment. Periods of less than thirty (30) days are treated as a full thirty (30)-day period, and the full interest charge is applied to any unpaid balance. Each payment is applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not allowable interest expenses. ()

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

c. The interest rate on overpayments and underpayments is compounded monthly. ()

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

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

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

b. The provider may: ()

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

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

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

032. – 034. (RESERVED)

035. RECORDS.

Providers must maintain records in sufficient detail to allow the Department to audit for compliance, medical necessity, quality assurance, and determination of payment methodology. The Department, the U.S. Department of Health and Human Services, and the Bureau of Compliance have the right to review pertinent records of providers

and related entities receiving Medicaid reimbursement. These reviews may be conducted for audit purposes outside of processes in IDAPA 16.05.07. ()

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

a. Withholding payments until access to the requested information is granted; ()

b. Recoupment of payments; or ()

c. Suspending the provider. ()

02. Undocumented Services. Undocumented services are subject to recoupment. ()

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

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

036. – 039. (RESERVED)

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

040. DOCUMENTATION FOR AUDITS.

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

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

03. Revenue Documentation. Must include the amount, date, purpose, and source of revenue. ()

04. Additional Documentation. ()

a. Providers are given an opportunity to provide documentation before an interim final audit report is issued. ()

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

041. – 044. (RESERVED)

045. RELATED PARTY TRANSACTIONS.

01. Principle. Allowability of costs applicable to services, facilities, and supplies furnished by entities related to the provider is subject to the regulations in 42 CFR 413.17, et al., and PRM. ()

02. Determination of Common Ownership or Control. A provider organization is related to a supplying organization as defined under 42 CFR 413.17. If the elements of common ownership or control are not present in both organizations, the organizations are deemed unrelated. ()

03. Cost to Related Organizations. The charges to a provider from related organizations may not exceed the billing to the related organization for these services. ()

04. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowed. ()

05. Interest Expense. Interest expense on loans between related entities is not reimbursable under Chapters 2, 10, and 12, PRM. ()

06. Exception. An exception to the general principle applicable to related organizations applies if the provider demonstrates they meet the requirements in 42 CFR 413.17(d). The exception is not applicable to sales, lease or rentals of hospitals, which do not meet the requirement that there be an open, competitive market for the facilities furnished under the PRM. ()

a. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. ()

b. When a facility is purchased from a related entity, the purchaser's depreciable basis must not exceed the seller's net book value under the PRM. ()

046. (RESERVED)

047. LONG-TERM CARE FACILITY PAYMENT.

Long-term care facilities are reimbursed the lower of their customary charges, their actual reasonable costs, adjusted by a BAF for NFs, or the standard costs for their class as set forth under the PRM. Upper payment limits must not exceed payments determined as reasonable costs under Medicare standards and principles. ()

048. – 049. (RESERVED)

SPECIFIC PROVIDER REIMBURSEMENT
(Sections 050-059)

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. Allowable compensation for providing administrative services is determined by: ()

i. All licensed beds in every facility administrative services are provided. ()

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

iii. Less than fifty-one (51) beds *being reimbursed at an allowable hourly rate. Non-administrative services are allowable at the reasonable market rate. Hours for each service type is documented. In no event will the*

total compensation for administrative and non-administrative duties exceed the limit applicable *for the same amount* for providing administrative services to facilities with fifty-one (51) *or more* beds. ()

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. ()

051. PCS AND AGED AND DISABLED WAIVER SERVICE COST SURVEYS.

The Department conducts cost surveys for one hundred percent (100%) of providers, customized for each of the services identified in this rule. Providers who refuse or fail to respond to state surveys may be disenrolled. The Department derives rates using direct care staff costs, employment related expenditures (ERE), program related costs, and indirect general and administrative costs in payment methodology, when these costs are incurred by a provider. ()

01. Wage Rates. Reimbursement methodology used when an expenditure is incurred by the provider type. Wages are identified on the Bureau of Labor Statistics (BLS) website at www.bls.gov when there is a comparable occupation title for direct care staff. When no comparable occupation title for direct care staff exists, then a weighted average hourly rate (WAHR) methodology is used. ()

02. ERE. ()

a. The BLS report at www.bls.gov for employer costs per hour worked for employee compensation and costs as a percent of total compensation for Mountain West Divisions are used to determine the incurred ERE by each provider type. ()

b. The Internal Revenue Service employer cost for social security and Medicare benefits at www.irs.gov is used to determine the incurred ERE by provider type. ()

03. Expenditures by Provider Type. Cost surveys are used to collect indirect general, administrative, and program related costs. Costs are ranked by costs per provider, and the Medicaid cost used in the rate methodology is established at the 75th percentile. ()

052. SPECIALIZED REIMBURSEMENT: CERTAIN HCBS AND CHIS.

01. Applicable HCBS and CHIS Programs. The following HCBS provider types and CHIS are reimbursed as described in this section: ()

- a.** Developmental Disability Agencies (DDA) providing services to adults or children; ()
- b.** Residential Habilitation Agencies; ()
- c.** Supported Employment Agencies; ()
- d.** Service Coordination Agencies; and ()
- e.** CHIS. ()

02. Timing, Description, and Rate Review Results. ()

a. The Department conducts a cost survey and reviews rates at least once every five (5) years for each provider type specified in this rule. Cost surveys are conducted in the order and on a schedule established by the Department. ()

b. The Department prepares an annual trigger analysis and publishes the report on the Medicaid Providers webpage. This annual report describes the triggers for interim rate reviews, a summary of data reviewed for each trigger, and the Department's determination and rationale of whether each trigger was met. The Department conducts interim rate reviews when one (1) or more of the following triggers occur: ()

i. Substantiated participant complaints, critical incidents, or both, related to a lack of qualified providers indicate emerging access issues; ()

ii. Department quality reports or substantiated participant complaints and critical incidents related to the quality of services indicate emerging quality issues; or ()

iii. Federal or Idaho minimum wage requirements in effect at the time of a standard rate review significantly change. ()

03. Cost Survey Procedures. The Department conducts periodic cost surveys. Providers who refuse or fail to respond may be disenrolled as a Medicaid provider. ()

04. Rate Setting Methodology. Providers must demonstrate that the average percent of wage and benefits paid to direct care staff (or service coordinators) meets or exceeds the percent of wages and ERE used to establish the rates for a service type. The cost components and new rates are established in accordance with the following components: ()

a. Direct Care Staff and Service Coordinator wages paid to agency employees or contractors who perform duties described in the applicable service description for at least seventy-five percent (75%) of the total annual amount of time compensated. ()

i. The wage component used to establish the new rate is set using the mean hourly wage of one (1) or more occupation profiles from the most current BLS State Occupational Employment and Wage Estimates table for Idaho that most closely aligns with the duties, education, and supervision requirements for staff providing the service

is used. If more than one (1) occupation profile aligns, then a weighted average of the mean hourly wage of multiple BLS occupation profiles is used. ()

ii. When no comparable occupation profile exists, then the wage component to establish the new rate is set using the WAHR of surveyed wages included in the final cost survey results. ()

iii. The Department makes the final determination of BLS occupation profiles. ()

iv. The Department evaluates an appropriate wage inflation factor based on economic data available at the time the rate is set. ()

b. ERE are expenses incurred by an agency to benefit direct care staff or service coordinators in these categories: paid leave, supplemental pay, payroll taxes, workers' compensation, insurance coverage, and retirement contributions. The ERE component percentage (ERE%) to establish a new rate is set using the cumulative percentage of employer costs for compensation from the most current BLS Employer Costs for Employee Compensation table for the West Region in the Mountain Division and IRS Publication 15. ()

c. Program-Related Expenses (PRE) are wages and other expenses supporting the objectives and provision of a service but not tied to any individual receiving a service. Regulatory requirements related to service delivery are PRE. ()

i. Program-related staff are agency employees who perform duties as required by statute or rule for at least seventy-five percent (75%) of the total annual amount of time compensated. ()

ii. Using data in the final cost survey results, each agency's PRE component percentage (PRE%) is calculated by dividing the agency's total PRE by their total wages. Each agency's PRE% is ranked and the mean of the PRE% rank is used to calculate a new rate. ()

d. General and Administrative (G&A) Expenses are wages and other expenses related to daily operations common across all businesses. ()

i. G&A staff are agency employees who perform administrative duties for at least seventy-five percent (75%) of the total annual amount of time compensated. ()

ii. Using data in the final cost survey results, each agency's G&A component percentage (G&A%) is calculated by dividing the agency's total G&A expenses by the sum of the agency's total wages, plus total ERE, total PRE, and total G&A expenses. Each agency's G&A% is ranked and the mean of the G&A% rank is used to calculate a new rate. ()

iii. The G&A% used to calculate a new rate will not exceed ten percent (10%) of the total rate per staff hour. ()

e. Total Rate Per Staff Hour of Service = $((\text{Wage} + (\text{ERE}\% \times \text{Wage}) + (\text{PRE}\% \times \text{Wage})) / (1 - (\text{G\&A}\%)))$. ()

f. The Department is not obligated to make budget requests based on the total rate per staff hour and takes into consideration factors of efficiency, economy, quality of care, and access to care when determining rates. Rates may be set at a percentage of the total rate per staff hour and are subject to approval by the Idaho Legislature. ()

g. The reimbursement rates calculated for CHIS include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location. ()

05. Quality Incentives. Based on the quality of services provided, a provider may be eligible for incentive payments. ()

a. Quality measures and associated payment percentages are established by the Department, in collaboration with the state's protection and advocacy organization designated by the Governor and described in the Idaho Medicaid Provider Handbook. The Department provides sixty (60) days prior notice of any substantive changes to quality measures and associated payment percentages. ()

b. Incentive payments are subject to availability of State and federal funds and may be rescinded if service quality declines. ()

053. ACCOUNTING TREATMENT.

GAAP, concepts, and definitions are used unless otherwise specified. When alternative treatments are available under GAAP, the acceptable treatment is the one that most clearly attains program objectives. ()

01. Final Payment. Final payment is made based on the reasonable cost of services as determined by audit under these rules. ()

02. Overpayments. Recovery of overpayments is attempted as quickly as possible consistent with the financial integrity of the provider resulting in two (2) circumstances: ()

a. For unfilled cost reports, all payments included in the recovery period and any subsequent payments are due. ()

b. Excessive reimbursement or non-covered services may precipitate immediate audit and settlement for the periods in question. When such a determination is made, the interim reimbursement rate (IRR) is reduced. This reduction is designated to discontinue overpayments (on an interim basis) or recover overpayments. ()

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

01. Services Requiring EVV. ()

a. Home Health. ()

b. State Plan PCS. ()

c. Attendant Care, Homemaker and Respite under the A&D Waiver. ()

02. EVV Requirements. Providers must: ()

a. Select and maintain an EVV system and certified as compliant with the Department's MMIS aggregator; ()

b. Retain documented participant consent for the provider's EVV methods; ()

c. Develop and maintain policies and procedures for use of EVV technology, including strategies for safeguarding participant data and privacy; and ()

d. Submit EVV data capturing six (6) system-validated data elements for services rendered: ()

i. Service date; ()

ii. Service start and end times; ()

iii. Direct service provider; ()

iv. Recipient of service; ()

v. Billable service; and ()

- vi. Service delivery location. ()
- e. Submit EVV data to the State's aggregator prior to billing claims. ()

055. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.

An exception is provided to the general rule applicable to related organizations if a provider demonstrates by convincing evidence to the satisfaction of an intermediary: ()

- 01. Supplying Organization.** Is a bona fide separate organization; ()

02. Non-Exclusive Relationship. A substantial part of the supplying organization's business activity type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control in an open, competitive market. ()

03. Sales and Rental of Extended Care Facilities. The exception is not applicable to sales, leases, or rentals of NFs or extended care facilities and do not meet the requirement that there be an open, competitive market for the facilities furnished. ()

- a. Rental expense for transactions between related entities is not recognized. Costs of ownership are allowed. ()
- b. When a facility is purchased from a related entity, the purchaser's depreciable basis will not exceed the seller's net book value. ()

056. – 059. (RESERVED)

EXCLUDED SERVICES
(Sections 060-069)

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. ()

061. INVESTIGATIONAL PROCEDURES OR TREATMENTS.

The Department may cover investigational procedures or treatments on a case-by-case basis for life-threatening conditions when no other treatment options are available. For these cases, a focused case review is completed by the Department. The Department will determine coverage based on this review. ()

01. Focused Case Review. A focused case review consists of assessment of: ()

a. Health benefit to the participant; ()

b. Risk to the participant; ()

c. Standard treatment for the participant's condition, including alternative treatments; ()

d. Specific inclusion or exclusion by Medicare national coverage guidelines; ()

e. Phase of the clinical trial of the proposed procedure or treatment; ()

- f.** Guidance regarding the proposed procedure or treatment by national organizations; ()
- g.** Pertinent clinical data and peer-reviewed literature; and ()
- h.** Ethics Committee review, if appropriate. ()

02. Additional Clinical Information. If there is insufficient information from the focused case review to render a coverage decision, the Department may seek an independent professional opinion. ()

062. – 069. (RESERVED)

MEDICAID BASIC PLAN COVERED SERVICES
(Sections 070-449)

SUB AREA: HOSPITAL SERVICES
(Sections 070-089)

070. HOSPITAL SERVICES: DEFINITIONS.

01. Administratively Necessary Day (AND). An Administratively Necessary Day (AND) is covered for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for NF level of care, or in-home services that are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. ()

02. All-Patient Refined Diagnosis Related Group (APR-DRG). A payment methodology outlined in the Medicaid Provider Agreement. ()

03. Allowable Costs. The current year's Medicaid apportionment of a hospital's allowable costs determined at final or interim settlement if cost settlements are applicable or determined using the version of the cost report used for prospective payment system (PPS) rate setting, consist of those costs permitted by the principles of reimbursement contained in the PRM and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. ()

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. ()

05. Charity Care. Charity care is care provided to individuals who have no source of payment, third-party or personal resources. ()

06. Critical Access Hospitals (CAH). A rural hospital as set forth in 42 CFR Section 485.620. ()

07. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. ()

08. Inpatient Customary Hospital Charges. Customary inpatient hospital charges reflect the regular rates for inpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. ()

a. All in-state providers not described in b. through d. below will be paid a final prospective payment rate using the APR-DRG classification system as described in these rules. ()

b. Idaho state-owned hospitals and the Department of Veteran's Affairs Medical Center will be reimbursed at one hundred percent (100%) of allowable cost using a retrospective cost settlement upon receipt of a

final Medicare cost report. ()

c. In-state and those out-of-state within thirty-five (35) miles of the Idaho border, CAHs will be reimbursed at one hundred one percent (101%) of allowable cost using a retrospective cost settlement upon receipt of a final Medicare cost report. ()

d. All out-of-state providers not described in a. through c. above will be paid a final prospective payment rate with no retrospective cost settlement using the APR-DRG classification system as described in these rules. The out-of-state APR-DRG rates were developed to provide a combined cost coverage of eighty-seven percent (87%) when all out-of-state providers are averaged together in keeping with Section 56-265(6)(b), Idaho Code. ()

09. Outpatient Services Customary Hospital Charges. Customary outpatient hospital charges reflect the regular rates for outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services be related to the cost of services billed to the Department. ()

a. Idaho state-owned hospitals and the Department of Veteran's Affairs Medical Center will be reimbursed at one hundred percent (100%) of allowable cost. ()

b. In-state and those out-of-state within thirty-five (35) miles of the Idaho border, CAHs will be reimbursed at one hundred one percent (101%) of allowable cost. ()

c. All hospitals that are not described in a. through b. above will be subject to the outpatient reimbursement parameters outlined in the Medicaid Provider Agreement and Section 56-265, Idaho Code. ()

10. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH allotment amount determined by CMS that is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. ()

11. Disproportionate Share Hospital (DSH) Survey. The DSH survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH payments. ()

12. Disproportionate Share Threshold. The disproportionate share threshold is: ()

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or ()

b. A Low-Income Revenue Rate exceeding twenty-five percent (25%). ()

13. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. ()

14. Low-Income Revenue Rate. The Low-Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: ()

a. Total Medicaid inpatient and outpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital in the same cost reporting period; plus ()

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments' county assistance programs. ()

15. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a

Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. ()

16. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH survey. Inpatient days includes ANDs, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. ()

17. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low-income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. ()

18. On-Site. A service location over which the hospital exercises financial and administrative control. "Financial and administrative control" means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location must be near the hospital where it is based, and both facilities serve the same patient population (e.g., from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital). ()

19. Reasonable Costs. Reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care that a prudent and cost-conscious hospital would pay for a given item or service. ()

20. Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the state Allotment Amount, both inpatient and outpatient costs of uninsured patients will be considered. ()

21. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. ()

071. INPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.
The policy, rules, and regulations to be followed are 42 CFR 456.50 through 42 CFR 456.145. ()

01. Initial Length of Stay. PA requirement for an initial length of stay will be established by the Department in the Idaho Medicaid Provider Handbook for hospitals not reimbursed under DRG methodologies. ()

02. Extended Stay. The Department will establish authorization requirements in the Idaho Medicaid Provider Handbook for hospitals not reimbursed under DRG methodologies. An authorization is necessary when the appropriate care of the participant indicates the need for hospital days more than the initial length of stay, or previously approved extended stay. ()

03. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services for hospitals not reimbursed under DRG methodologies: ()

a. Payment for accommodations is limited to the hospital's all-inclusive rate. The all-inclusive rate is a flat fee charge incurred daily that covers both room and board. ()

b. The Department will not authorize reimbursement above the all-inclusive rate unless the attending provider orders a room that is not an all-inclusive rate room because of medical necessity. ()

04. Diagnosis Related Group (DRG) Review and Audits. All services performed under DRG are subject to QIO reviews, retrospective reviews, and audits. The Department reserves the right to execute reviews as described in the Idaho Medicaid Provider Handbook as amended. ()

072. INPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Certification of Medical Necessity. At the time of admission, the physician must certify that inpatient services are necessary. Recertification must occur at least every sixty (60) days inpatient hospital services are required but may be required more frequently as determined by the Department. ()

02. Individual Plan of Care. The individual plan of care is a written plan developed for the participant upon admission to a hospital and updated at least every sixty (60) days but may be required more frequently as determined by the Department. Requirements are defined in the Idaho Medicaid Provider Handbook. ()

03. Request for Extended Stay. To qualify for reimbursement, authorization must be obtained from the Department. The request should be made before the initial length of stay or previously authorized extended stay ends and submitted as designated by the Department. Documentation for the request should include the most recent plan of care. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. ()

073. INPATIENT HOSPITAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

Only a Medicare certified hospital, licensed by the state in which it operates, may enroll in the Idaho Medicaid program. Hospitals not participating as a Medicaid swing-bed provider, which are licensed for long-term care or as a specialty hospital that provides a nursing home level of care, will be reimbursed as a NF. Hospitals not eligible for enrollment which render emergency care will be paid rates established in these rules. ()

074. HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.

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

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

a. The participant's admission and length of stay may be subject concurrent review, continued stay review, and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. Failure to obtain a timely QIO review as required by these rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. ()

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

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

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

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

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

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

a. Routine services include all medical care, supplies, and services that are included in the calculation of NF property and non-property costs as described in these rules. Reimbursement of ancillary services will be

determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except prescription drugs will be reimbursed under these rules. ()

b. The Department will reimburse hospitals for participants under the following conditions: ()
i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05;
and ()

ii. The participant is authorized for payment of long-term care. ()

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

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

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

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

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

v. Reimbursement of ancillary services not included in the NF rates furnished for extended care
services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with
Medicare reasonable cost principles, except that reimbursement for prescription drugs under these rules. ()

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

a. Mandatory Eligibility for DSH status will be provided for hospitals that: ()

i. Meet or exceed the disproportionate share threshold under these rules. ()

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

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

(2) Does not offer nonemergency inpatient obstetric services. ()

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

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

v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal
to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean

of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. ()

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

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

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

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

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

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

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

i. Five dollars (\$5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or ()

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. ()

c. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. ()

d. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. ()

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third-party payment. ()

ii. Claims of uninsured costs that increase the maximum amount that a hospital may receive as a DSH payment must be documented. ()

e. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. ()

f. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. ()

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to

the Medicaid Fraud Unit of the Idaho Attorney General's Office. ()

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." ()

iii. If based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: ()

(1) Recover the overpayment from the provider; and ()

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. ()

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the SSA. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. ()

05. Out-of-State Hospitals. Hospitals will have a cost settlement computed with the state of Idaho if the following conditions are met: ()

a. Total inpatient and outpatient covered charges are more than fifty thousand dollars (\$50,000) in the fiscal year; or ()

b. When less than fifty thousand dollars (\$50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. ()

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

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

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

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

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

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

10. Interim Reimbursement Rates for Providers Subject to Cost Settlement. The interim

reimbursement rates must be reasonable and adequate to meet the necessary costs that are incurred by economically and efficiently operated providers that provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. ()

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

b. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. ()

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

075. INPATIENT HOSPITAL SERVICES: QUALITY ASSURANCE.

The designated QIO must prepare, distribute, and maintain a provider manual that is periodically updated. The manual must include the following: ()

01. QIO Information. The QIO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. ()

02. Department Provisions. Department-selected diagnoses and procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. ()

03. Approval Timeframe. A provision that the QIO will inform the hospital of a certification within five (5) days, or other time frame as determined by the Department, of an approved admission, transfer, or continuing stay. ()

04. Method of Notice. The method of notice to hospitals of QIO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. ()

05. Procedural Information. The procedures that providers or participants will use to obtain reconsideration of a denial by the QIO prior to appeal to the Department. Such requests for reconsideration by the QIO must be made in writing to the QIO within one hundred eighty (180) days of the issuance of the "Notice of Non-Certification of Hospital Days." ()

076. – 079. (RESERVED)

080. OUTPATIENT HOSPITAL SERVICES: DEFINITIONS.

Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative or palliative items, and services furnished by or under the direction of a provider not in need of inpatient hospital care, unless excluded by any other provisions of this chapter. ()

081. (RESERVED)

082. OUTPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.

01. Services Are Provided On-Site. ()

02. Co-Payments. ()

a. When an emergency room physician determines that an emergency condition does not exist, the hospital can require the participant to pay a co-payment. ()

b. Services may be refused when determined an emergency condition does not exist, and the participant does not make the co-payment at the time of service. The hospital will provide notification to the participant per Section 1916A(e) of the SSA. ()

083. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. **Review Prior to Delivery.** Failure to obtain a timely review from the Department prior to delivery of listed procedure and diagnosis codes in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, will result in a retrospective review. ()

02. **Follow-Up for Emergency Room Patients.** Hospitals must coordinate care of patients who have a PCP. ()

084. (RESERVED)

085. OUTPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.

The Department will not pay more than the combined payments the provider is allowed to receive from the participants and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. Providers subject to cost settlement, outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year-end cost settlement. Maximum payment for hospital-based ambulance services, hospital outpatient diagnostic laboratory and partial care services will be limited to the Department's fee schedule. ()

086. – 089. (RESERVED)

SUB AREA: AMBULATORY SURGICAL CENTERS
(Sections 090-099)

090. – 091. (RESERVED)

092. AMBULATORY SURGICAL CENTER SERVICES: COVERAGE AND LIMITATIONS.

Surgical procedures identified by the Medicare program as appropriately and safely performed in an ASC will be reimbursed by the Department. The Department may add surgical procedures to the list developed by the Medicare program if the procedures meet the criteria in 42 CFR 416.166. ()

093. (RESERVED)

094. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

The ASC must be surveyed as required by 42 CFR 416.25 through 416.52 and be approved by the U.S. Department of Health and Human Services for participation as a Medicare ASC provider. ()

095. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER REIMBURSEMENT.

ASC services reimbursement is packaged for use of facilities and necessary supplies as recognized by the Medicare program under 42 CFR, Part 416.164. The Department will establish a reimbursement rate for any covered procedure not covered by Medicare. ()

096. – 099. (RESERVED)

SUB AREA: CASE MANAGEMENT SERVICES
(Sections 100-109)

100. CASE MANAGEMENT.

01. **Home Visiting Services.** Home visiting provides for parents of vulnerable children to receive education and support on parenting topics. ()

02. Community Re-entry Services. Community re-entry services provide targeted case management for eligible incarcerated participants. ()

101. CASE MANAGEMENT: PARTICIPANT ELIGIBILITY.

01. Home Visiting Services. Participants under five (5) years of age and pregnant women at risk for abuse, neglect, or child welfare involvement. Additional requirements are in the Idaho Medicaid Provider Handbook. ()

02. Community Re-entry Services. Eligible participants are those incarcerated with an adjudicated case up to age twenty-one (21) for the general population and up to age twenty-six (26) for those formerly in foster care. ()

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. ()

103. (RESERVED)

104. CASE MANAGEMENT: PROVIDER QUALIFICATIONS AND DUTIES.

Home visiting services are provided by the Public Health Districts or their designee. Eligible providers are certified in an evidence-based model including either Parents as Teachers, or Nurse-Family Partnership. ()

105. – 109. (RESERVED)

SUB AREA: MEDICAL SERVICES
(Sections 110-119)

110. MEDICAL SERVICES.

Medical services include the treatment of medical and surgical conditions by licensed professionals subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage under these rules. ()

111. MEDICAL SERVICES: PARTICIPANT ELIGIBILITY.

The Department will fund abortions under circumstances where the abortion is necessary to save the life of the woman. ()

112. MEDICAL SERVICES: COVERAGE AND LIMITATIONS.

- 01. Adult Physicals.** Adult preventive physical examinations are limited to one (1) per year. ()
- 02. Injectable Vitamins.** Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. ()
- 03. Reconstructive Surgery.** Reconstruction or restorative procedures include procedures that restore function of the affected or related body part(s). Covered procedures include breast reconstruction after mastectomy, or the repair of other injuries resulting from physical trauma. ()
- 04. Screening Mammograms.** Screening mammograms are covered when aligned with the “A” or “B” recommendations of the United States Preventative Services Task Force. ()
- 05. Tonometry.** Payment for tonometry is limited to one (1) examination or, when the examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed for participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. ()
- 06. Weight Loss Surgical Procedures.** Abdominoplasty or panniculectomy is covered when the surgery is prior authorized by the Department. The request for PA must include the following documentation: ()
- a.** Photographs of the front, side and underside of the abdomen; ()
 - b.** Treatment of any ulceration and skin infections involving the panniculus; ()
 - c.** Failure of conservative treatment, including weight loss; ()
 - d.** That the panniculus severely inhibits the participant's walking; ()
 - e.** That the participant is unable to wear a garment to hold the panniculus up; and ()
 - f.** Other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body. ()

113. MEDICAL SERVICES: PROCEDURAL REQUIREMENTS.

Abortion procedures require a licensed physician to certify in writing that the woman may die if the fetus is carried to term. ()

114. MEDICAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

- 01. Locum Tenens Claims and Reciprocal Billing.** Locum Tenens is allowed as detailed in the Idaho Medicaid Provider Handbook. ()
- 02. Misrepresentation of Services.** Any representation of a service provided by a provider other than a physician as a physician service is prohibited. ()
- 03. Weight Loss Surgical Procedures.** Physicians and hospitals performing surgical procedures must meet national medical standards for weight loss surgery. ()

115. – 118. (RESERVED)

119. MEDICAL SERVICES: DIAGNOSTIC SCREENING CLINICS.

The Department will reimburse medical social service visits to clinics that coordinate the treatment between providers for participants which are diagnosed with cerebral palsy, myelomeningitis or other neurological diseases

and injuries with comparable outcomes. ()

01. Multidisciplinary Assessments and Consultations. The clinic must perform on site multidisciplinary assessments and consultations with each participant and responsible parent or guardian. Diagnostic and consultive services related to the diagnosis and treatment of the participant will be provided by board certified provider specialists in physical medicine, neurology and orthopedics. ()

02. Billings. No more than five (5) hours of medical social services may be billed each state fiscal year for which the medical social worker monitors and arranges treatments and provides medical information to providers coordinating their care. ()

03. Provider Qualifications. The clinic will be a separate and distinct entity from the hospital or other provider practices. ()

SUB AREA: OTHER PROVIDER SERVICES
(Sections 120-179)

120. CHIROPRACTIC SERVICES: DEFINITIONS.
Subluxation is partial or incomplete dislocation of the spine. ()

121. (RESERVED)

122. CHIROPRACTIC SERVICES: COVERAGE AND LIMITATIONS.
Only treatment involving manipulation of the spine to correct a subluxation condition is covered. ()

123. – 130. (RESERVED)

131. DIABETES EDUCATION AND TRAINING SERVICES: PARTICIPANT ELIGIBILITY.
Medical necessity for diabetes education and training are evidenced by the following: ()

01. Participants with Diabetes. Are eligible for a Diabetes Management Program when: ()

a. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or ()

b. Uncontrolled diabetes manifested by two (2) or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or ()

c. Recent manifestations from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. ()

02. Participants with Pre-Diabetes. Are eligible for the National Diabetes Prevention Program when they meet the program's guidance. ()

132. DIABETES EDUCATION AND TRAINING SERVICES: COVERAGE AND LIMITATIONS.

01. Concurrent Diagnosis. Only services that are reasonable and necessary will be covered. Covered professional and educational services will address each participant's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, exercise, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. ()

02. No Substitutions. Providers may not use the formally structured program, or a Certified Diabetes Care and Education Specialist (CDCES), as a substitute for basic diabetic care and instruction, which includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of oral hypoglycemic agents. ()

03. Services Limited. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. ()

133. DIABETES EDUCATION AND TRAINING SERVICES: PROCEDURAL REQUIREMENTS.
To receive diabetes counseling, the participant must have a written order and referral. ()

134. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Diabetes Management Program. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association or Association of Diabetes Care and Education Specialists by a CDCES, dietitian, or pharmacist. ()

02. The National Diabetes Prevention Program. The provider meets the requirements for the program. ()

135. – 139. (RESERVED)

140. LICENSED MIDWIFE (LM) SERVICES.
The Department will reimburse LMs for maternal and newborn services performed within the scope of their practice. This section of rule does not include services provided by a nurse midwife. ()

141. LM SERVICES: PARTICIPANT ELIGIBILITY.
LM services are available for participants in maternity, or newborn participants. ()

142. LM SERVICES: COVERAGE AND LIMITATIONS.

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

02. Medication. Covered medication listed in the LM formulary under IDAPA 24.26.01. ()

143. – 145. (RESERVED)

146. LM SERVICES: PROVIDER QUALITY ASSURANCE ACTIVITIES.
Each LM provider must maintain for Department review documentation of informed consent and practice data. ()

147. – 149. (RESERVED)

150. NUTRITIONAL SERVICES.
Nutritional services include intensive nutritional education, counseling, and monitoring. The need for nutritional services must be discovered by screening services and ordered by the provider. ()

151. – 161. (RESERVED)

162. OPTOMETRIST SERVICES: COVERAGE AND LIMITATIONS.
The Department will pay for vision services for the diagnosis and treatment of injury or disease of the eye. ()

163. – 169. (RESERVED)

170. PODIATRIST SERVICES: DEFINITIONS.

01. Acute Foot Conditions. An acute foot condition means any condition that hinders normal function, threatens the individual, or complicates any disease. ()

- 02. Chronic Foot Diseases.** Chronic foot diseases include: ()
- a.** Diabetes mellitus; ()
- b.** Peripheral neuropathy involving the feet; ()
- c.** Chronic thrombophlebitis; ()
- d.** Peripheral vascular disease; ()
- e.** Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds, pressure ulcers, or amputation; or ()
- f.** Other conditions that have the potential to seriously or irreversibly compromise overall health. ()

171. PODIATRIST SERVICES: PARTICIPANT ELIGIBILITY.

Participants eligible for podiatrist services are those with a(n): ()

- 01. Chronic Disease.** ()
- 02. Acute Condition.** An acute condition that, if left untreated, may cause an adverse outcome to the participant's health. ()

172. PODIATRIST SERVICES: COVERAGE AND LIMITATIONS.

Coverage for podiatrist services is limited to preventive foot care services for chronic foot conditions and acute conditions that if left untreated will result in chronic damage to the participant's foot. ()

173. – 179. (RESERVED)

SUB AREA: CHIS
(Sections 180-189)

180. CHIS: DEFINITIONS.

- 01. Assessment and Clinical Treatment Plan (ACTP).** A comprehensive assessment that guides the formation of the implementation plan(s) that include developmentally appropriate objectives and strategies related to identified needs. ()
- 02. Aversive Intervention.** Uses unpleasant physical or sensory stimuli to reduce undesired behavior. The stimuli usually cannot be avoided or is pain inducing. ()
- 03. Community.** Natural, integrated environments outside the participant's home, outside of DDA center-based settings, or at school outside of school hours. ()
- 04. Developmental Disabilities Agency (DDA).** ()
- 05. Duplicate Services.** ()
- a.** Goals are not separate and unique to each service provided; or ()
- b.** When more than one (1) service is provided at the same time, unless otherwise authorized. ()
- 06. Fidelity.** The consistent and accurate implementation of children's habilitation services in accordance with the modality, manual, protocol, or model. ()

181. CHIS: ELIGIBILITY REQUIREMENTS.

Participants are eligible from birth through the month of their twenty-first birthday. Participants must have a demonstrated functional need or a combination of functional and behavioral needs that require intervention services to correct or ameliorate their condition. A functional or behavioral need is determined by the Department approved screening tool when a deficit is identified in three (3) or more of the following areas: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency; or maladaptive behavior. A deficit is defined as one-point-five (1.5) or more standard deviations below the mean for functional areas or above the mean for maladaptive behavior. ()

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. ()

183. CHIS: PROCEDURAL REQUIREMENTS.

All CHIS identified on a participant's ACTP must be prior authorized by the Department and maintained in each participant's file. CHIS providers are responsible for documenting and submitting the ACTP and obtain PA before delivering any CHIS. ()

01. Prior Authorization (PA) Request. Must be submitted to the Department. The provider, and parent or legal guardian will be notified of the decision. ()

a. Once the initial request for PA is submitted, CHIS may be delivered for a maximum of twenty-four (24) hours and up to thirty (30) calendar days or until the PA is approved. ()

- b.** Initial PA requests must include: ()
 - i. An order from a provider; and ()
 - ii. The ACTP. ()
- c.** Ongoing PA requests must include: ()
 - i. A list of the participant's goals and objectives; ()
 - ii. A written summary of data regarding progress or lack of progress to meeting each objective, including graphs showing change lines; ()
 - iii. A list of all CHIS hours being requested and the qualification of the individual(s) who will provide them; and ()

- iv. An updated annual ACTP, if applicable. ()
- d. The following services may be requested retroactively: ()
 - i. The initial ACTP; ()
 - ii. The screening tool; and ()
 - iii. Crisis intervention within seventy-two (72) hours of the service initiation. ()

02. Implementation Plan(s). A qualified provider will complete and sign an implementation plan with details on how intervention will be implemented. All implementation plan objectives must be related to a need identified on the ACTP. The provider must document that a copy of the participant's implementation plan(s) was offered to the participant's parent or legal guardian. Any restrictive or aversive interventions being implemented must be reviewed and approved by a licensed or certified individual working within the scope of their practice. ()

03. Documentation. For each participant, the following program documentation is required for each visit made or service provided: ()

- a. Date, time, and duration; ()
- b. Summary of session or service provided, and if interdisciplinary training is provided, who the service was delivered to, and the content covered; ()
- c. Data documentation that corresponds to the implementation plans for habilitative skill building or behavioral intervention; ()
- d. Location of service delivery; and ()
- e. Signature of the individual providing the service, date signed, and credential. ()

04. Supervision. Supervision includes both face-to-face observation and direction to the staff regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant. Supervision must be provided under the requirements of the EBM or each provider qualification. Intervention specialists providing services to children birth to three (3) years old must be supervised by a specialist or professional who also meets the birth to three (3) years old requirements. ()

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. ()

185. CHIS: PROVIDER REIMBURSEMENT.

The reimbursement rates calculated for CHIS include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location. ()

186. CHIS: QUALITY ASSURANCE.

The Department will establish performance criteria to meet federal assurances that measure the outcomes and effectiveness of CHIS. ()

01. Quality Assurance. Quality assurance reviews assure compliance with the Department's rules and regulations for CHIS. Identified problems that impact health and safety or are not resolved through quality improvement activities, will have implementation of a corrective action process. ()

- 02. Quality Improvement.** Activities may include any of the following: ()
- a.** Consultation; ()
- b.** Technical assistance and recommendations; or ()
- c.** A Corrective Action. A formal process used by the Department to address significant, ongoing, or unresolved deficient practices identified during the review process under these rules. Corrective action includes: ()
- i.** Issuance of a corrective action plan; ()
- ii.** Reporting to Medicaid Program Integrity Unit; or ()
- iii.** Action against a provider agreement. ()

187. – 189. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 190-199)

190. PREVENTIVE HEALTH ASSISTANCE (PHA): DEFINITIONS.
Behavioral PHA are benefits to support weight control. ()

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)*. ()

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

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

- a.** Maximum Benefit Points. ()
- i.** The maximum number of points for a Behavioral PHA is two hundred (200) each benefit year. ()
- ii.** The maximum number of points for the Wellness PHA benefit is one hundred twenty (120) each benefit year. ()
- b.** Points expire at the end of the participant's benefit year. ()
- c.** Points cannot be transferred to, or combined with, points in another participant's PHA benefit. ()

02. Weight Management Program. Each program must provide weight management services with at least one (1) of the following: ()

- a.** Physical fitness; ()
- b.** Balanced diet; or ()
- c.** Personal health education. ()

03. Premiums. Wellness PHA benefit points are only used to offset a participant's premiums to maintain eligibility under IDAPA 16.03.01, if applicable. Only ten (10) points may be applied per month. ()

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

01. Behavioral PHA. A participant must complete a PHA Benefit Agreement Form to earn two hundred (200) points. ()

02. Wellness PHA. Each participant must demonstrate that they have received recommended wellness visits and immunizations for their age prior to earning any points. Ten (10) points can be earned each month by for receiving all recommended wellness visits and immunizations for their age during the benefit year. ()

194. (RESERVED)

195. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER REIMBURSEMENT.

The provider may bill the participant for the difference between the Department's reimbursement and the provider's usual and customary charge for provided Behavioral PHA products or services with the prior agreement of the participant. ()

196. EARLY INTERVENTION SERVICES.

Early Intervention Services for participants are provided by the Idaho Infant Toddler Program (ITP). Services are coordinated through an intra-agency agreement published on the Department's website. Reimbursement is in accordance with the intra-agency agreement. ()

197. – 199. (RESERVED)

SUB AREA: LABORATORY AND RADIOLOGY SERVICES
(Sections 200-209)

200. LABORATORY AND RADIOLOGY SERVICES: DEFINITIONS.

01. Independent Laboratory. A laboratory not located in a provider's office and that receives specimens from a source other than another laboratory. ()

02. Laboratory or Clinical Laboratory. A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of material derived from the human body to provide information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. ()

03. Proficiency Testing. Evaluation of a laboratory's ability to perform laboratory procedures within acceptable limits of accuracy through analysis of unknown specimens distributed at periodic intervals. ()

04. Quality Control. Analysis of reference materials to ensure reproducibility and accuracy of laboratory results, and an acceptable system to assure proper functioning of instruments, equipment, and reagents. ()

05. Reference Laboratory. A laboratory that only accepts specimens from other laboratories. ()

201. – 202. (RESERVED)

203. LABORATORY AND RADIOLOGY SERVICES: COVERAGE AND LIMITATIONS.

01. Laboratory Services. ()

02. Radiology Services. ()

204. LABORATORY AND RADIOLOGY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Laboratory and Radiology Requirements. Providers of laboratory and radiology services must be eligible for Medicare certification for these services. ()

02. Use of Reference Laboratories. Laboratories using reference laboratories must ensure that all requirements of these rules are met by the reference laboratory. ()

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. ()

206. LABORATORY AND RADIOLOGY SERVICES: QUALITY ASSURANCE.

Laboratories, as a condition of payment, must maintain a quality-control program, including proficiency testing under 42 USC Section 263a. The laboratory must provide the results to the Department upon request. ()

207. – 209. (RESERVED)

SUB AREA: PRESCRIPTION DRUGS
(Sections 210-219)

210. PRESCRIPTION DRUGS: DEFINITIONS.

Unit Dose: Drugs packaged in individual, sealed doses with tamper-evident packaging such as, but not limited to, single unit-of-use, blister packaging, unused injectable vials, and ampules. ()

211. PRESCRIPTION DRUGS: PARTICIPANT ELIGIBILITY.

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

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 54-1705A, 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. ()

213. PRESCRIPTION DRUGS: PROCEDURAL REQUIREMENTS.

01. Request for PA. ()

a. PA is initiated by the prescriber by submitting the request to the Department in the prescribed format. ()

b. Whenever possible, the Department will use automated authorization, in which claims are adjudicated at point of sale using submitted National Council for Prescription Drug Programs (NCPDP) data elements or claims history to verify the Department's authorization requirements have been satisfied, without the need for the prescriber to submit additional clinical information. ()

02. Response to Request. The Department will respond within twenty-four (24) hours to a request for PA of a covered outpatient prescription drug under 42 U.S.C. 1396r-8(d)(5)(A). ()

03. Supplemental Rebates. ()

a. Supplemental rebates may be one (1) factor considered in determining a drug's preferred drug status, but secondary to considerations of the safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable drugs. ()

b. The Department may negotiate with manufacturers supplemental rebates for prescription drugs that are in addition to those required by Title XIX of the SSA. There is no upper limit on the dollar amounts of the supplemental rebates the Department may negotiate. ()

04. Dispensing Procedures. The following protocol is required for prescription filling: ()

a. Refills must be authorized by the prescriber on the original or new prescription order on file and each refill must be recorded on the prescription, logbook, computer print-out, or participant's medication profile. Automatic refills are not allowed. All refills must be initiated by a request from the participant, prescriber, or another person, acting as an agent of the participant. Authorization for each refill must be received prior to the beginning of

the filling process by the pharmacy. ()

b. Prescriptions must be maintained on file in pharmacies and available for immediate review by the Department upon written request. ()

05. Return of Unused Prescription Drugs. Drugs dispensed in unit dose packaging must be returned to the dispensing pharmacy when the participant no longer uses the medication. The pharmacy that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the professional dispensing fee. ()

214. PRESCRIPTION DRUGS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Enrollment. Pharmacies will enroll with the Department using the specific location where the service was performed. ()

02. Out-of-State Providers. An out of state pharmacy shipping or mailing a prescription into Idaho must have a valid mail order license issued by the Idaho Board of Pharmacy. ()

215. PRESCRIPTION DRUGS: PROVIDER REIMBURSEMENT.

Medicaid pharmacies are reimbursed based on Actual Acquisition Costs (AAC) except where noted. Medicaid may require providers to supply documentation of their AACs under the Medicaid Pharmacy Claims Submission Manual available at: https://idaho.fhsc.com/downloads/providers/IDRx_Pharmacy_Claims_Submission_Manual.pdf. Reimbursement is restricted to drugs supplied from labelers participating in the CMS Medicaid Drug Rebate Program. ()

01. Pharmacy Reimbursement. Prescriptions not filled according to dispensing procedures will be subject to nonpayment or recoupment. The following protocol is required for reimbursement. ()

a. Reimbursement is limited to the lowest of the following: ()

i. AAC based on results of the periodic state cost survey under this rule, plus professional dispensing fee. In cases where no AAC is available, reimbursement will be the Wholesale Acquisition Cost (WAC). WAC is the price, for a given calendar quarter, paid by a wholesaler for the drugs purchased from the wholesaler's supplier. The wholesaler's supplier is typically the manufacturer of the drug as published by a recognized compendium of drug pricing for the same calendar quarter; ()

ii. State Maximum Allowable Cost (SMAC), as established by the Department, plus professional dispensing fee; ()

iii. Federal Upper Limit (FUL), as established by CMS, plus professional dispensing fee; or ()

iv. The provider's usual and customary charge to the general public. ()

b. The Department will utilize periodic state cost surveys to obtain the most accurate pharmacy drug AACs in establishing a pharmacy reimbursement fee schedule. Pharmacies participating in the Medicaid Pharmacy Program are required to participate in these periodic state cost surveys by disclosing the costs of all drugs. A pharmacy that is non-responsive to the periodic state cost surveys can be disenrolled as a Medicaid provider by the Department. ()

c. Provider Administered Drugs. ()

i. Reimbursement to providers that are not 340B-covered entities for medications administered to participants by providers will be: ()

(1) Ninety percent (90%) of the published Medicare Average Sales Price plus six percent (6%) rate (ASP+6% rate). ()

- (2) If the ASP+6% rate is not available, payment will be at the WAC. ()
- (3) If the ASP and WAC are not available, an invoice from the manufacturer or wholesaler is required, reimbursement will be at cost plus ten percent (10%). Radiopharmaceuticals will be paid additionally for the cost of shipping. ()
- ii. Reimbursement to 340B covered entities for medications administered to participants by providers will be the actual 340B drug AAC, not to exceed the 340B ceiling price. ()
- d. Clotting Factors. ()
- i. Reimbursement to specialty pharmacies will be at a state-based price equivalent to the published Medicare ASP+6% rate, plus professional dispensing fee. ()
- ii. Reimbursement to Hemophilia Treatment Centers will be the 340B AAC, not to exceed the 340B ceiling price. ()
- e. Professional Dispensing Fee is a tier-based amount paid on a pharmacy claim, over and above the ingredient cost, to compensate the provider for the pharmacist's professional services related to dispensing a prescription to a participant, including: ()
- i. Verifying a participant's coverage; ()
- ii. Performing drug use reviews and preferred drug list review activities; ()
- iii. Measuring or mixing the covered outpatient drug; ()
- iv. Filling the container; ()
- v. Participant counseling; ()
- vi. Physically providing the completed prescription to the participant; ()
- vii. Special packaging; and ()
- viii. Overhead associated with maintaining the facility and equipment necessary to operate the dispensing entity. ()
- f. Only one (1) professional dispensing fee per month is allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: ()
- i. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; ()
- ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; ()
- iii. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or ()
- iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. ()
- g. The Department will survey providers to establish a professional dispensing fee for each provider. The professional dispensing fees will be paid based on the provider's total annual claims volume. The provider must return the claims volume survey to the Department by May 31st each year. Providers who do not complete the survey

will be assigned the lowest professional dispensing fee starting on July 1st until the next annual survey is completed. Based upon the annual claims volume of the enrolled pharmacy, the professional dispensing fee is provided online at: <https://healthandwelfare.idaho.gov/providers/pharmacy-providers/idaho-medicaid-pharmacy-program>. ()

02. 340B-Covered Entity Reimbursement. ()

a. Participation as a 340B-Covered Entity. Medicaid will reimburse 340B covered entities under Section 340B of the Public Health Service Act, defined in 42 U.S.C. 256b(a)(4), when the provider meets the following requirements: ()

i. A 340B-covered entity submits its unique 340B identification number issued by the Health Resources and Services Administration (HRSA) and a copy of its completed HRSA 340B registration to Medicaid. ()

ii. A provider that elects to provide drugs to Medicaid participants through the 340B drug pricing program must use 340B-covered outpatient drugs for all dispensed or administered drugs, including those dispensed through the entity's retail pharmacy or administered in an outpatient clinic. A 340B-covered entity must ensure that a contract pharmacy does not dispense drugs, or receive Medicaid reimbursement for drugs, acquired by the 340B-covered entity through the 340B drug pricing program. An entity that does not comply will be carved out of the 340B drug pricing program. ()

iii. A 340B-covered entity must provide Medicaid with thirty (30) days written notice of its intent to discontinue the provision of drugs acquired through the 340B drug pricing program to participants. ()

b. Drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies are not covered. ()

c. Reimbursement to 340B-covered entities is limited to their actual 340B drug AAC submitted, not to exceed the 340B ceiling price, plus professional dispensing fee. ()

03. Reimbursement for Drugs Dispensed by Other Provider Types. ()

a. Drugs acquired through non-340B Indian Health Service, Tribal, or Urban Indian pharmacies will be reimbursed at the AAC to the entity, plus professional dispensing fee. ()

b. Drugs acquired via the Federal Supply Schedule (FSS) will be reimbursed at the FSS AAC, plus professional dispensing fee. ()

c. Drugs acquired at nominal price, defined as pricing that is outside of 340B regulations or FSS, will be reimbursed at the AAC, plus professional dispensing fee. ()

d. Specialty drugs not dispensed by retail community pharmacies and dispensed primarily through the mail will be reimbursed at the Idaho AAC, if such cost is available, plus professional dispensing fee. If the AAC is not available, drugs will be reimbursed at the lower of the WAC or SMAC as established by the Department, plus the assigned professional dispensing fee. ()

e. Drugs not distributed by a retail community pharmacy, such as drugs dispensed in a long-term care facility or dispensed to participants receiving swing-bed services, under these rules, will be reimbursed at the actual ingredient cost, plus professional dispensing fee. ()

04. Limitations on Payment. ()

a. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for those covered by Medicaid. ()

b. Medicaid may conduct drug utilization reviews and impose limitations for participants whose drug utilization exceeds the standard participant profile or disease management guidelines determined by the Department. ()

()
05. **Cost Appeal Process.** Cost appeals will be determined by the Department's process provided online. ()

216. – 219. (RESERVED)

SUB AREA: FAMILY PLANNING
(Sections 220-229)

220. (RESERVED)

221. FAMILY PLANNING SERVICES: PARTICIPANT ELIGIBILITY.

01. **Sterilization Procedures.** Sterilization procedures are only a covered service when they meet the requirements in 42 CFR 441.253, 42 CFR 441.257, and 42 CFR 441.258. ()

02. **Hysterectomies.** Payment can be made for a hysterectomy only if: ()

a. The participant was advised orally and in writing that sterility would result in the inability to bear children; and ()

b. The participant signs and dates a form that meets the requirements of the Idaho Medicaid Provider Handbook. ()

c. Claims require supporting documentation attached to the claim. ()

222. FAMILY PLANNING SERVICES: COVERAGE AND LIMITATIONS.

Family planning includes counseling and medical services prescribed or performed by a provider. Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization. ()

01. **Contraceptive Supplies.** ()

a. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. ()

b. Payment for oral contraceptives is limited to purchase of a six (6) month supply. ()

02. **Sterilization.** ()

a. No sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are payable unless such sterilizations are ordered by a court of law. ()

b. Hysterectomies are subject to these rules. ()

c. All requirements of state or local law for obtaining consent, except for spousal consent, must be followed. ()

03. **Exceptions to Sterilization Time Requirements.** If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the participant's signature on the consent form; and ()

a. In the case of premature delivery, the provider must also state the expected date of delivery and describe the emergency in detail; and ()

b. Describe, in writing to the Department, the nature of any emergency necessitating emergency

abdominal surgery; and ()

c. Under no circumstance can the period between consent and sterilization exceed one hundred eighty (180) days. ()

04. Requirements for Sterilization Performed Due to a Court Order. The performing provider must have been provided with a copy of the court order prior to the performance of the sterilization, and: ()

a. Certify that all requirements have been met concerning sterilizations; and ()

b. Submit a copy of the court order together with the “Consent Form” and claim. ()

223. FAMILY PLANNING SERVICES: PROCEDURAL REQUIREMENTS.

Informed consent exists when a properly completed “Consent Form”, or its equivalent, is submitted to the Department together with the physician's claim for the sterilization. Completed informed consent forms must meet all the requirements in 42 CFR 441.258, to be eligible for reimbursement. The person obtaining informed consent must ensure and certify all the requirements in 42 CFR 441.257 have been met. If the individual obtaining the consent and the physician who will perform the sterilization procedure are the same person, that person must sign both statements on the consent form. ()

224. (RESERVED)

225. FAMILY PLANNING SERVICES: PROVIDER REIMBURSEMENT.

Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost. ()

226. – 229. (RESERVED)

SUB AREA: BEHAVIORAL HEALTH SERVICES
(Sections 230-239)

230. (RESERVED)

231. BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.

All participants eligible for Medicaid are automatically enrolled in the managed care plan to access medically necessary behavioral health services. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for inpatient services. ()

232. BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

Covered services are those which evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. ()

233. BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Enrollment. Providers will enroll in the managed care plan with the contractor and meet both the credentialing and quality assurance guidelines of the contractor. ()

02. Authorization. The managed care contractor is responsible for authorization of covered behavioral health services that require PA. ()

03. Complaints, Grievances, and Appeals. Complaints, grievances, and appeals are handled between the contractor and the Department in compliance with state and federal requirements. Participants will utilize the complaint, grievance, and appeal process required by the contractor prior to initiating an administrative appeal with the Department. ()

234. BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. All Services. Services are delivered by network providers who are enrolled with the contractor and meet reimbursement, quality, and utilization standards. The contractor will enter into agreements with enrolled providers to provide the services. ()

02. Inpatient Services. Inpatient hospital psychiatric services must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the state in which they provide services. To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services. General hospitals licensed to provide services in their state, but are not JCAHO certified, may not bill for psychiatric services beyond emergency screening and stabilization. All inpatient services must comply with 42 CFR Part 456 when applicable. ()

235. BEHAVIORAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.

Provider agreements will include the reimbursement methodology agreed upon by the contractor and Department. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric services. ()

236. – 239. (RESERVED)

SUB AREA: HOME HEALTH SERVICES
(Sections 240-249)

240 – 241. (RESERVED)

242. HOME HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Services. Home health services and items include nursing services, home health aide services, physical therapy, occupational therapy, speech-language pathology services, audiology services, and medical supplies, equipment, and appliances provided under a home health plan of care. ()

02. Settings. Home health services are covered in a participant's residence and any setting in which normal life activities take place. Services are not covered in a: ()

a. Any setting in which Medicaid covers inpatient services, including room and board; or ()

b. ICF/IID, unless such services are not otherwise required to be provided by the ICF/IID. ()

03. Limitations. Home health services are limited to one hundred (100) visits per calendar year per person. Provision of durable medical equipment or supplies is not a visit. ()

04. Requirements. Services and items, when appropriate, will meet the requirements for: ()

a. Audiology services under these rules; ()

b. Medical supplies, items, and appliances under these rules; ()

c. Physical therapy, occupational therapy, and speech-language pathology services under these rules; and ()

d. Early Periodic, Screening, Diagnosis, and Treatment Services under these rules. ()

243. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Orders. ()

a. Home health services require an order including the ordering provider's NPI, the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which the home health

services will be needed. ()

b. Home health services must be reordered at least every sixty (60) days for services and annually for medical supplies, equipment, and appliances. ()

02. Home Health Plan of Care. All home health services must be provided under a home health plan of care that is established prior to beginning treatment and must be signed by the provider who established the plan. ()

244. ELECTRONIC VISIT VERIFICATION (EVV). Home Health Agencies (HHAs) are required to submit claims using EVV for all services provided except for the provision of medical supplies and equipment. ()

245. (RESERVED)

246. HOME HEALTH SERVICES: PROVIDER REIMBURSEMENT.

01. Home Health Services. Payment for home health must not exceed the lesser of reasonable cost as determined by a finalized Medicare cost report or the Medicaid percentile cap. ()

a. The Medicaid percentile cap is revised annually, effective at the beginning of each state fiscal year. Revisions are made using the data from the most recent finalized Medicare cost reports thirty (30) days prior to the effective date. ()

b. Payment by the Department for home health will include mileage as part of the visit. ()

c. Provider claims for services requiring EVV will include the corresponding EVV data elements. EVV data will be submitted to the state's aggregator prior to billing claims. ()

d. If a person is eligible for Medicare, all services ordered by the provider will be purchased by Medicare. The Department will pay for the deductible and co-insurance. ()

02. Medical Supplies, Equipment, and Appliances. Payment uses general procedures. ()

247. – 249. (RESERVED)

SUB AREA: THERAPY SERVICES
(Sections 250-259)

250. THERAPY SERVICES: DEFINITIONS.

01. Duplicate Services. Services are considered duplicate: ()

a. When participants receive any combination of physical therapy, occupational therapy, or speech-language pathology services with treatments, evaluations, treatment plans, or goals that are not separate and unique to each service provided; or ()

b. When more than one (1) type of therapy is provided at the same time. ()

02. Feeding Therapy. Services necessary for the treatment of feeding disorders. ()

03. Maintenance Program. A program that requires the skills of a therapist or therapy professional and consists of activities and mechanisms to assist a participant in maximizing or maintaining the progress they have made during therapy or to prevent or slow further deterioration due to a disease or illness. ()

04. Occupational Therapy Services. Therapy services that: ()

a. Are necessary for the evaluation and treatment of impairments, functional disabilities, or changes in physical function and health status; and ()

b. Improve the ability to perform tasks required for independent functioning. ()

05. Physical Therapy Services. Therapy services that: ()

a. Are necessary for the evaluation and treatment of physical impairment or injury using therapeutic exercise and the application of modalities to restore optimal function or normal development; and ()

b. Focus on the rehabilitation and prevention of neuromuscular, musculoskeletal, integumentary, and cardiopulmonary disabilities. ()

06. Speech-Language Pathology Services. Therapy services that are: ()

a. Necessary for the evaluation and treatment of speech and language disorders that result in communication disabilities; or ()

b. Necessary for the evaluation and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. ()

07. Therapeutic Procedures. Therapeutic procedures are the application of clinical skills, services, or both, that attempt to improve function. ()

08. Therapist. An individual licensed by the appropriate state licensing board as an occupational therapist, physical therapist, or speech-language pathologist. ()

09. Therapy Professional. An individual licensed by the appropriate state licensing board as an occupational therapist or occupational therapist assistant, physical therapist or physical therapist assistant, or speech-language pathologist or speech-language pathology assistant. ()

10. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are therapy services. These services are ordered as part of a plan of care. ()

251. THERAPY SERVICES: PARTICIPANT ELIGIBILITY.

Participants are eligible with an evaluation showing a need for therapy due to a functional limitation, a loss or delay of skill, or both that establishes the participant will demonstrate progress because of therapy services. ()

252. THERAPY SERVICES: COVERAGE AND LIMITATIONS.

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

01. Therapy Services. Services described in the Idaho Medicaid Provider Handbook are covered with the following limitations: ()

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

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

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

02. Non-Covered Therapy Services. ()

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

b. Services for developmentally acceptable error patterns. ()

c. Services that do not require the skills of a therapy professional. ()

d. Massage, work hardening, and conditioning. ()

e. Biofeedback, unless provided to treat urinary incontinence. ()

03. Service Limitations. ()

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

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

253. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.

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

01. Orders. ()

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

b. Therapy services provided under home health must comply with the order requirements in home health instead. ()

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

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

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

i. Diagnoses; ()

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

iii. Type, frequency, and duration of therapy services. ()

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

254. (RESERVED)

255. THERAPY SERVICES: PROVIDER REIMBURSEMENT.

The payment for therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. Reimbursement

is paid as: ()

01. Home Health Agencies. A per visit rate. ()

02. Independent Therapists. Fee-for-service. A therapy assistant cannot bill Medicaid directly. ()

03. Hospital Services. A rate not to exceed the payment determined as reasonable cost using Medicare standards and principles. ()

04. Long-term Care Facilities. Bundled into the facility reimbursement for participants. ()

05. School-based Services. As per its subsection. ()

256. THERAPY SERVICES: QUALITY ASSURANCE ACTIVITIES.

01. Therapist Conditions and Requirements. The therapist is required to formulate all therapy interventions in accordance with the applicable licensure rules as well as the applicable association's professional code of ethics and standards supporting best practice. ()

02. Documentation. The following documentation must be maintained in the files of the provider: ()

a. Provider orders for therapy services; ()

b. Therapy plans of care; and ()

c. Progress or other notes documenting each assessment, therapy session, and results of tests and measurements related to therapy services. ()

257. – 259. (RESERVED)

SUB AREA: AUDIOLOGY SERVICES
(Sections 260-269)

260. AUDIOLOGY SERVICES.

Audiology services are diagnostic, screening, preventive, or corrective services provided by an audiologist, and in accordance with Title 54, Chapter 29, Idaho Code, require the order of a provider. Audiology services do not include equipment needed by the patient such as communication devices or environmental controls. ()

261. (RESERVED)

262. AUDIOLOGY SERVICES: COVERAGE AND LIMITATIONS.

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

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

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

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

263. AUDIOLOGY SERVICES: PROCEDURAL REQUIREMENTS.

01. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedance testing must be ordered in writing. ()

02. Provider Documentation Requirements. Documentation of the following must be kept on file by the provider: ()

a. The participant's diagnosis; ()

b. The results of the basic comprehensive audiometric exam that include pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedance testing; and ()

c. The brand name and model type of the hearing aid with warranty and insurance information. ()

03. Warranties. Providers will exercise the use of warranties or insurance during the first year following the purchase of the hearing aid when applicable. Provider services are included in the purchase of the non-implantable hearing aid for the first two (2) years and one (1) year for implantable hearing aid including proper fitting and refitting of the ear mold or aid, instructions on the aid's use, and extended insurance coverage. ()

04. Waiver of Impedance Test. The Department will allow a physician or non-physician practitioner to waive the impedance test based on their documented judgment. ()

264. – 269. (RESERVED)

**SUB AREA: DURABLE MEDICAL EQUIPMENT, PROSTHETICS,
ORTHOTICS, AND SUPPLIES (DMEPOS)**
(Sections 270-279)

270. – 271. (RESERVED)

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. ()

273. DMEPOS: PROCEDURAL REQUIREMENTS.

01. Orders. ()

a. All equipment and medical supplies must be ordered by a provider within the scope of their licensure. Orders must meet the requirements in the CMS/Medicare DME coverage manual, be kept on file with the DME provider, and include: ()

i. The medical diagnosis requiring the use of the item; and ()

ii. How long the item will be necessary and frequency of use, and for pro re nata (PRN) orders the conditions for use. ()

b. Medical equipment and supplies must be reordered at least annually. ()

c. Not more than ninety (90) days may elapse between the order date and date of a PA request. ()

02. Rental Procedures. When specified by the Department, equipment must be rented. ()

a. Rental payments, including intermittent payments, are applied to the purchase of the equipment. ()

b. The Department may choose to rent equipment without purchasing it. ()

c. The monthly rental payment will be one-tenth (1/10) of the purchase price. ()

274. (RESERVED)

275. DMEPOS: PROVIDER REIMBURSEMENT.

01. Items Included in Per Diem Excluded. No payment will be made for any items included in the per diem payment for inpatient care in a hospital, NF, or ICF/IID. ()

02. Date of Service. Unless specifically authorized by the Department, the date of services for DME and supplies is the date of delivery for items provided in-person or the date of shipment for supplies mailed through a third-party courier. ()

03. Warranties and Cost of Repairs. No reimbursement will be made for the cost of repairs (materials or labor) covered under the manufacturer's warranty. The date of purchase and the warranty period must be kept on file by the DME provider. The following warranty periods are required to be provided on equipment purchased by the Department: ()

a. An ultra-light or high-strength lightweight wheelchair must have a lifetime warranty period on the frame and crossbraces; ()

b. All electrical components and new or replacement parts must have a minimum six (6) month warranty period; ()

c. All other DME not specified under this rule must have a minimum one (1) year warranty period; ()

d. If the manufacturer denies the warranty due to user misuse or abuse, that information must be forwarded to the Department at the time of the request for repair or replacement; and ()

e. The monthly rental payment must include a full-service warranty. All routine maintenance, repairs, and replacement of rental equipment are the responsibility of the provider. ()

276. DMEPOS: QUALITY ASSURANCE.

The Department has no obligation to repair or replace any piece of DME that has been damaged, defaced, lost, or destroyed because of neglect, abuse, or misuse. ()

277. – 279. (RESERVED)

SUB AREA: VISION SERVICES
(Sections 280-289)

280. – 281. (RESERVED)

282. VISION SERVICES: COVERAGE AND LIMITATIONS.

Vision services are administered through a managed care contractor. ()

01. Eye Examinations. One (1) eye examination is covered during any twelve (12) month period to determine the need for glasses to correct a refractive error. ()

02. Eyeglasses and Contacts. Eyewear is covered when needed for correction of a refractive error. ()

a. Lenses will be covered once every four (4) years except when there is documentation of a major visual change. ()

i. Scratch resistant coating is required for all plastic and polycarbonate lenses. ()

ii. Tinted lenses are restricted to extreme medical conditions defined by the Department. ()

b. Contact lenses will be covered only for: ()

i. A need for correction equal to or greater than plus or minus ten (± 10) diopters; or ()

ii. An extreme medical condition that does not allow correction using conventional lenses, such as cataract surgery, keratoconus, anisometropia, or other conditions defined by the Department. ()

c. One (1) set of frames is covered once every four (4) years except when receiving new lenses that do not fit in existing frames. ()

- d.** Fitting fees are covered only when the participant is eligible for the associated supplies. ()
- 03. Vision Therapy.** Vision therapy is covered for participants between the ages of nine (9) and twenty-one (21) with a diagnosis of convergence insufficiency. ()
- 04. Non-Covered Items.** Trifocal lenses, Progressive lenses, and photo gray. ()
- 05. Participant Responsibility.** Participants are responsible for replacement of broken, lost, or missing glasses. ()
- 283. – 284. (RESERVED)**
- 285. VISION SERVICES: PROVIDER REIMBURSEMENT.**
The Department will designate a supplier to provide all eyeglass frames and lenses. ()
- 286. – 289. (RESERVED)**

SUB AREA: DENTAL SERVICES
(Sections 290-299)

- 290. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE.**
Dental benefits are provided through a managed care contractor. ()
- 291. DENTAL SERVICES: DEFINITIONS.**
- 01. Adults.** Participants past the month of their twenty-first birthday. ()
- 02. Children.** Participants from birth through the month of their twenty-first birthday. ()
- 292. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.**
All participants are eligible for dental benefits. ()
- 293. DENTAL SERVICES: COVERAGE AND LIMITATIONS.**
Covered dental services may be subject to limitations from the managed care contractor or benefit restrictions according to the terms of its contract with the Department, in addition to these rules. ()
- 01. Dental Coverage for Children.** Children are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, endodontic services (including root canals and crowns), periodontics, prosthodontic, orthodontic treatments, dentures, and oral surgery. Orthodontics are limited to children who meet Medicaid eligibility requirements as determined by the State's contractor. ()
- 02. Dental Coverage for Adults.** Adults are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, periodontics, prosthodontic, dentures, oral surgery, and endodontic services with limitations. Root canals and crowns are not covered. ()
- 294. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.**
- 01. Administer the Dental Benefit.** The managed care contractor is responsible for administering the dental benefit, including dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. ()
- 02. Authorization.** The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. ()
- 03. Grievances.** The contractor is responsible for tracking and reporting all grievances to the State's contract monitor. ()

04. Appeals. Appeals are handled by a process between the contractor and the Department as specified by the Office of Administrative Hearings, and in compliance with state and federal requirements. ()

295. DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

Providers must enroll in the managed care contractor network with the dental insurance contractor and meet both credentialing and quality assurance guidelines of the contractor, and the licensing requirements of the Idaho Board of Dentistry standards or the applicable state in which services are provided. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. ()

296. DENTAL SERVICES: PROVIDER REIMBURSEMENT.

The contractor reimburses dental providers on a fee-for-service basis under a Department-approved fee schedule. The State will collaborate with the contractor to establish rates that promote and ensure adequate access to dental services. ()

297. DENTAL SERVICES: QUALITY ASSURANCE.

Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud, overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered. ()

298. – 299. (RESERVED)

SUB AREA: ESSENTIAL PROVIDERS
(Sections 300-329)

300. FQHC AND RHC SERVICES: DEFINITIONS.

01. Change in Intensity of Services. A change in the intensity of services means a change in the quantity and complexity of services delivered that could change the total allowable cost per encounter. This does not include an expansion or remodeling of an existing provider. This may include the addition of new services or the deletion of existing services. ()

02. Encounter. An encounter, for payment purposes, is a face-to-face contact for the provision of medical, mental or dental services between a FQHC or RHC patient and a provider as specified in Subsections 303.01 through 303.15. ()

03. Federally Qualified Health Centers (FQHCs). FQHCs are defined in federal law at 42 USC Section 1396d(l)(2)(A), (B), and 42 USC Section 1395x(aa)(4), and includes community health centers, migrant health centers, providers of care for the homeless, and outpatient health programs or clinics operated by a tribe or tribal organizations under the Indian Self-Determination Act (P.L. 93-638). It also includes clinics that qualify for, but are not actually receiving, grant funds according to Sections 329, 330, or 340 of the Public Health Service Act (42 USC Sections 201, et seq.) that may provide ambulatory services to Medicaid participants. ()

04. Medicare Cost Report Period. The period of time covered by the Medicare-required annual report of cost. ()

05. Medicare Economic Index (MEI). An annual measure of inflation designed to estimate the increase in the total cost for the average physician to operate a medical practice and takes into account cost categories such as a physician's own time, non-physician employee's compensation, rents, and medical equipment. The MEI is used in establishing the annual changes to the payment conversion factors used in the methodology for determining reimbursement rates. ()

06. Rural Health Clinic (RHC). An RHC is located in a rural area designated as a physician shortage area and is neither a rehabilitation agency nor does it primarily provide for the care and treatment of mental diseases. ()

301. – 302. (RESERVED)

303. FQHC AND RHC SERVICES: COVERAGE AND LIMITATIONS.

FQHC and RHC services are defined as follows: ()

01. Physician Services. ()

02. Physician Assistant Services. ()

03. Nurse Practitioner or Clinical Nurse Specialist Services. ()

04. Visiting Nurse Services. Part-time or intermittent nursing care, and related medical services to a home bound individual, when an RHC located in an area with a shortage of home health agencies. ()

05. Chiropractor Services. ()

06. Podiatrist Services. ()

07. Clinical Psychologist Services. ()

08. Licensed Social Worker Services. ()

09. Licensed Clinical Social Worker Services. ()

10. Licensed Masters Social Worker Services. ()

11. Licensed Professional Counselor Services. ()

12. Licensed Clinical Professional Counselor Services. ()

13. Licensed Marriage and Family Therapist Services. ()

14. Other DOPL Licenses. Any other behavioral health or substance use disorder license type recognized by the Idaho Division of Occupational and Professional Licensing (DOPL). ()

15. Licensed Dentist and Dental Hygienist Services. ()

16. Pharmacist Services. ()

17. Incidental Services and Supplies. Services and supplies incident to a provider listed in Subsections 303.01 through 303.15 as would otherwise be covered by a physician service are part of an encounter; or ()

18. Other Payable Services. Other ambulatory services covered by Medicaid that the FQHC or RHC undertakes to provide, including immunizations. These services are billed separately from an encounter. ()

304. – 305. (RESERVED)

306. FQHC AND RHC SERVICES: REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for FQHC and RHC services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42USC Section 1396a(bb), Subsections (1) through (4). ()

02. FQHC or RHC Encounter. Each contact with a separate discipline of health professional (medical, mental or dental), on the same day at the same location, is reimbursed as a separate encounter. All contact with all practitioners within a disciplinary category (medical, mental or dental) on the same day is a single encounter. ()

- a.** Reimbursement for services is limited to one (1) encounter per discipline per participant per day. ()
- b.** An additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later than the first encounter and requires additional diagnosis or treatment. ()
- c.** The encounter rate does not include drugs for biologicals which cannot be self-administered, long-acting reversible contraception (LARC) or non-surgical transcervical permanent female contraceptive devices. ()

307. FQHC AND RHC: RATE SETTING METHODOLOGY.

01. Prospective Payment System. ()

- a.** The Department will establish separate, finalized rates for medical/mental and dental encounters. The Department will prospectively set these finalized encounter rates using the FQHC's medical/mental and dental encounter costs. ()
- b.** The Department will pay each provider an encounter rate equal to the amount paid in the previous federal fiscal year. The Department will adjust the encounter rate for inflation using the Medicaid Economic Index (MEI), as published by CMS. ()
- c.** If an out-of-state FQHC becomes an Idaho Medicaid provider and provides less than one hundred (100) Idaho Medicaid encounters or receives less than ten thousand dollars (\$10,000) in Idaho Medicaid payments in the first year after entering the program, the Department will deem the FQHC a low utilization provider. The finalized encounter rate for low utilization providers will be the same as the interim encounter rate as defined under these rules. If there is an increase in the number of encounters or the amount of payments over any twelve (12) month Medicare cost report period, the Department reserves the right to audit a low utilization provider's Medicare cost report in order to set a new interim encounter rate as defined under these rules. ()

02. New Providers to Idaho Medicaid. ()

- a.** If the provider is new, the Department will set the interim encounter rate by referring to the encounter rates paid to other providers in the same or adjacent regional areas with similar caseloads. Regional areas are defined by the Department. If encounter rate information for others in the same or adjacent regional areas with similar caseloads is not available, the Department will set the interim encounter rate using historical cost information. If historical cost information is not available, the Department will use budgeted cost and encounter information submitted by the provider. ()
- b.** If the provider has been designated as an FQHC or RHC for at least twenty-four (24) consecutive months and provides the historical cost and encounter information for this period to the Department, the Department will use the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. The Department will provide the provider a supplemental information worksheet to complete. This worksheet will be used by the Department to identify dental encounters and other incidental costs related to either medical/mental or dental encounters. ()
- c.** For both new and existing providers that become Idaho Medicaid providers, the Department will audit the Medicare cost report for the twenty-four (24) consecutive months that represent two (2) complete fiscal years after the FQHC has become a Medicaid provider. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. ()
- d.** For both new and existing FQHCs that become Idaho Medicaid providers, the Department will adjust the finalized encounter rate annually for inflation in accordance with these rules. ()
- e.** The Department will adjust the claim payments for all provider claims paid at the interim encounter rate(s). These adjustments will reflect the payment at the finalized encounter rate(s). The Department will pay the provider for any total adjustment amount over what was reimbursed. The provider must pay the Department for any

total adjustment amount that is under what was reimbursed. ()

03. Change in an Encounter Rate Due to a Change in Scope of Services. ()

a. After an approval is obtained for a change in scope of service from the federal Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, the provider must request the Department to review the encounter rate(s). This will include reviewing the addition of a new service(s), deletion of an existing service(s), or other changes in the intensity of services offered by the provider that could change the total cost per encounter. The provider must request the Department to review the encounter rate(s) within sixty (60) days after the approval from the HRSA Bureau of Primary Health Care for a change in scope of service. The Department requires the same supporting documentation required by the HRSA Bureau of Primary Health Care. ()

b. When the provider does not have to file a change in scope of service with the HRSA Bureau of Primary Health Care, but plans an increase or decrease in the intensity of services to be offered that will result in a change to the scope of services, the provider must request the Department to review the request for a change in intensity and determine if there will be an increase or decrease in the encounter rate(s). The Department will review the request for a change in intensity within sixty (60) days of the planned change. ()

c. The Department reserves the right to audit the Medicare cost report and recalculate the encounter rates when a change in the scope of service is reported. ()

d. The Department will determine the encounter rate in accordance with this rule when the provider had reported a change in scope of service. The Department will audit the most recent twenty-four (24) consecutive months of Medicare cost reports following any change(s) in the scope of service. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. The finalized encounter rate(s) for both medical/mental and dental encounters will be recalculated and audited using the Medicare cost report for the second full twelve (12) month period. ()

04. Annual Filing Requirements. Each provider is required to file a copy of its Medicare cost report on an annual basis. Department deadlines are the same as those imposed by Medicare. ()

308. – 311. (RESERVED)

312. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: COVERAGE AND LIMITATIONS. Payment will be available to Indian Health Service (IHS) clinics for any service provided within the conditions of the scope of care and services described for FQHC and RHC services. ()

313. – 314. (RESERVED)

315. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Procedure. Payment for services other than prescribed drugs will be made on a per visit basis at a rate not exceeding the outpatient visit rate established by the Federal Office of Management and Budget as published annually in the Federal Register. ()

02. Dispensing Fee for Prescriptions. The allowed dispensing fee used to compute maximum payment for each prescription will be the midpoint dispensing fee of the range of fees in effect at the date of service unless a higher fee is justified by a pharmacy cost of operations report on file with the Department. ()

03. Third-Party Liability Not Applicable. ()

316. – 319. (RESERVED)

320. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Individual Educational Plan (IEP). ()

02. School-Based Services (SBS). SBS are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). ()

03. Serious and Persistent Mental Illness (SPMI). A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-5-TR with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. ()

321. SBS: PARTICIPANT ELIGIBILITY.

01. Age. Twenty-one (21) years of age or younger and the semester in which their twenty-first birthday falls is not finished. ()

02. Parental Consent. A one-time parental consent to access public benefits or insurance from a parent or legal guardian for Medicaid reimbursement. ()

322. SBS: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.

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

a. A student under eighteen (18) years of age meeting the Serious Emotional Disturbance (SED) eligibility criteria in the Children's Mental Health Services Act, Section 16-2403(13), Idaho Code. The child must experience a substantial impairment in functioning. The level and type of impairment must be documented in the school record. A Department-approved assessment must be used for an initial functional impairment score. Subsequent scores must be obtained annually to determine changes in functioning as a result of mental health treatment. ()

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

- i. Vocational or educational; ()
- ii. Financial; ()
- iii. Social relationships or support; ()
- iv. Family; ()
- v. Basic living skills; ()
- vi. Housing; ()
- vii. Community or legal; or ()

viii. Health or medical. ()

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

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

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. ()

324. SBS: PROCEDURAL REQUIREMENTS.

Documentation requirements: ()

01. IEP and Other Service Plans. Providers may bill for services covered by a current IEP, transitional Individualized Family Service Plan (IFSP), or Services Plan (SP) defined in the Idaho Special Education Manual for parentally placed private school students with disabilities when designated funds are available for special education and related services. The plan must be within the previous three hundred sixty-five (365) days and the need for one (1) or more medically necessary health-related service and lists all the Medicaid reimbursable services for which the provider is requesting reimbursement. The IEP and transitional IFSP must include: ()

- a.** Type, frequency, and duration of the service provided; ()
- b.** Title of the provider, including the direct care staff delivering services under the supervision of the professional; ()
- c.** Measurable goals, when goals are required for the service; and ()
- d.** Specific place of service, if provided in a location other than school. ()

02. Evaluations and Assessments. ()

03. Service Detail Reports. A service detail report that includes: ()

- a.** Name of student; ()
- b.** Name, title, and signature of the person providing the service; ()
- c.** Date, time, and duration of service; ()

- d. Place of service, if provided in a location other than school; ()
- e. Category of service and brief description of the specific areas addressed; and ()
- f. Student's response to the service when required for the service. ()
- 04. One Hundred Twenty Day Review.** A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. ()
- 05. Documentation of Qualifications of Providers.** ()
- 06. Recommendations or Referrals Required.** SBS require a recommendation or referral within thirty (30) days of the provision of services and at least every three hundred sixty-five (365) days. ()
- 07. Requirements for Cooperation.** Each provider must act in cooperation with students' parent or guardian, and with community and state agencies and professionals who provide like Medicaid services to the student. This includes: ()

 - a. Documentation that parents or guardians were notified of the services billed to Medicaid that describes the service, provider, and the type, location, frequency, and duration of the service. ()
 - b. Documentation that parents or guardian were provided with a current copy of the child's plan and any pertinent addenda. ()
 - c. Requesting the name of the student's PCP with a written consent to release and obtain information between the PCP and the school from the parent or guardian. ()
 - d. Upon receiving a request for a copy of the evaluations or the current plan, the provider furnishing the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. ()
- 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. ()
- 326. SBS: PROVIDER REIMBURSEMENT.** ()
Only school districts and charter schools can be reimbursed for SBS. ()
- 01. Recoupment of Federal Share.** Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. ()
 - 02. Matching Funds.** Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. Providers must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: ()
 - a.** Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. ()
 - b.** Providers will send the Department the matching funds, either by check or automated clearing house (ACH) electronic funds transfers. ()
 - c.** The Department will hold matching funds in an interest-bearing trust account. The average daily balance during a month must exceed one hundred dollars (\$100) in order to receive interest for that month. ()
 - d.** The payments to the districts will include both the federal and non-federal share (matching funds). ()
 - e.** Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. ()
 - f.** If sufficient matching funds are not received in advance, all Medicaid payments to the school

district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed, and reimbursement will be made during the next payment cycle. ()

g. The Department will provide the school districts a monthly statement that will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. ()

h. The school districts will estimate the amount of their next billing, and the amount of matching funds needed to pay the Department. ()

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. ()

327. SBS: QUALITY ASSURANCE AND IMPROVEMENT.

01. Audit. If problems are identified during an audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department will work with the school to answer questions and provide clear direction regarding the corrective action plan. ()

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate student satisfaction, outcomes monitoring, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for the students. ()

328. – 329. (RESERVED)

SUB AREA: MEDICAL TRANSPORTATION SERVICES
(Sections 330-349)

330. (RESERVED)

331. EMERGENCY TRANSPORTATION SERVICES: PARTICIPANT ELIGIBILITY.

Ambulance services are medically necessary when an emergency condition exists. For purposes of reimbursement, an emergency condition exists when a participant manifests acute symptoms or signs, or both, which, by reasonable medical judgment of the Department, represent a condition of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in death, serious impairment of a bodily function or major organ, or serious jeopardy to the overall health of the participant. If such condition exists, and treatment is required at the participant's location, or transport of the participant for treatment in another location by ambulance is the only appropriate mode of travel, the Department will review such claims and consider authorization for emergency ambulance services. ()

332. EMERGENCY TRANSPORTATION SERVICES: COVERAGE AND LIMITATIONS.

01. Local Transport Only. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the participant was transported, payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities and the service is authorized by the Department. ()

02. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: ()

a. The point of pickup is inaccessible by land vehicle; or ()

b. Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential; and ()

c. Air ambulance service will be covered where the participant's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. ()

03. **Co-Payments.** When the Department determines that the participant did not require emergency transportation, the provider can bill the participant for the co-payment. ()

333. EMERGENCY TRANSPORTATION SERVICES: PROCEDURAL REQUIREMENTS.

01. **Services Subject to Review.** Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. ()

02. **Non-Emergency Transport PA Required.** If an emergency does not exist, prior written authorization to transport by ambulance must be secured from the Department. The provider must provide justification to the Department that any other mode of travel would, by reasonable medical judgment of the Department, result in death, serious impairment of a bodily function or major organ, or serious jeopardy to the overall health of the participant. ()

03. **Air Ambulance.** Air ambulance services must be approved in advance by the Department, except in emergency situations. Emergency air ambulance services will be authorized by the Department on a retrospective basis. ()

334. EMERGENCY TRANSPORTATION SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. **Licensure Required.** All Emergency Medical Services (EMS) Providers must hold a current license issued by their states' EMS licensing authority. Payment will not be made to ambulances that do not hold a current license. ()

02. **Air Ambulance.** The operator of the air service must bill the Department directly. ()

335. EMERGENCY TRANSPORTATION SERVICES: PROVIDER REIMBURSEMENT.

Payment for ambulance services is subject to the following: ()

01. Ambulance Reimbursement Base Rate. ()

a. The base rate for ambulance services includes customary patient care equipment and items such as stretchers, clean linens, reusable devices and equipment. The base rate also includes nonreusable items, and disposable supplies such as oxygen, triangular bandages and dressings that may be required for the care of the participant during transport. In addition to the base rate, the Department will reimburse mileage. ()

b. Licensed personnel are required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a base rate according to the following: ()

i. The level of personnel required to be in the patient compartment of the ambulance; ()

ii. The level of ambulance license the unit has been issued; and ()

iii. The level of life support authorized by the Department. ()

c. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Basic Life Support (BLS) rate. Units with Advanced Emergency Medical Technician-Ambulance (AEMT-A) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level I (ALSI) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level II (ALSII) rate. When a participant's condition requires hospital-to-hospital transport with ongoing care that must be furnished by one (1) or more health care professionals in an appropriate specialty area, including emergency or critical care nursing, emergency medicine, or a paramedic with

additional training, Specialty Care Transport (SCT) may be authorized by the Department. ()

02. Multiple Providers. If multiple licensed EMS providers are involved in the transport of a participant, only providers who transport the participant will be reimbursed for services. ()

a. In situations where personnel and equipment from a licensed ALSII provider boards an ALSI or BLS ambulance, the transporting ambulance may bill for ALSII services as authorized by the Department. ()

b. In situations where personnel and equipment from a licensed ALSI provider boards an ALSII or BLS ambulance, the transporting ambulance may bill for ALSI services as authorized by the Department. ()

c. In situations where medical personnel and equipment from a medical facility are present during the transport of the participant, the transporting ambulance may bill at the ALSI or ALSII level of service. The transporting provider must arrange to pay the other provider for their services. ()

d. If multiple licensed EMS providers transport a participant for different legs of a trip, each provider must bill their base rate and mileage. ()

e. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department. ()

f. If a physician is in attendance during transport, they are responsible for the billing of their services. ()

03. Round Trips and Standby. ()

a. If an ambulance returns to a base station after having transported a participant to a facility and the participant's provider orders the participant to be transferred from this facility to another facility because of medical need, two (2) base rate charges, in addition to the mileage, will be considered for reimbursement. If an ambulance vehicle and crew do not return to a base station and the patient is transferred from one (1) facility to another facility, charges for only one (1) base rate, waiting time, and mileage will be considered. ()

b. Round trip charges will be allowed only when a facility in-patient is transported to the nearest facility with necessary specialized services not available in the original facility. ()

c. Reimbursement for waiting time will not be considered unless documentation submitted to the Department identifies the length of the waiting time and established its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips. ()

04. Treat and Release. The Department may reimburse the EMS provider at the appropriate base rate if they respond to an emergency situation and treat and release the participant without transport. ()

05. Response and Evaluation. The Department may reimburse the EMS provider if they respond to a participant's location, and no treatment or transport is necessary. No payment will be made if the EMS provider responds and no evaluation is done, or the participant has left the scene. No payment will be made to an EMS provider who is licensed as a non-transporting provider. ()

336. – 339. (RESERVED)

340. NEMT SERVICES: DEFINITIONS.

01. Contracted Transportation Provider. A provider who is under contract with the transportation broker to provide NEMT for participants. ()

02. NEMT. NEMT is transportation that is: ()

a. Not of an emergency nature; and ()

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

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

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

341. NEMT SERVICES: DUTIES OF THE TRANSPORTATION BROKER.

The transportation broker under contract with the Department is required to: ()

01. Coordinate and Manage. Coordinate and manage all NEMT services for Medicaid participants statewide. ()

02. Contract With Transportation Providers. Contract with transportation providers throughout the state to provide NEMT services for Medicaid participants. ()

03. Call Center. Operate a call center to receive and review NEMT for Medicaid participants meeting NEMT requirements. ()

04. Authorize NEMT Services. Authorize NEMT services for Medicaid participants requesting transportation and who meet NEMT requirements. ()

05. Reimburse Contracted Transportation Providers. Reimburse contracted transportation providers for NEMT services meeting the NEMT requirements. ()

06. Safe and Professional Transportation. Assure that contracted transportation providers deliver NEMT services in a safe and professional manner. ()

342. NEMT SERVICES: COVERAGE AND LIMITATIONS.

01. NEMT Services. The transportation broker will reimburse contracted transportation providers for NEMT services under the following conditions: ()

a. The travel is essential to get to or from a covered service; ()

b. The mode of transportation is the least costly that is appropriate for the medical needs of the participant; ()

c. The transportation is to the nearest medical provider appropriate to perform the needed services, and transportation is by the most direct route practicable; ()

d. Other modes of transportation, including personal vehicle, assistance by family, friends, and charitable organizations, are unavailable or impractical under the circumstances; ()

e. The travel is authorized and scheduled by the transportation broker; and ()

f. The contracted transportation provider follows the terms of its contract with the transportation broker. ()

02. Travel-Related Services. The transportation broker will reimburse a contracted transportation provider for travel-related services under the following circumstances: ()

a. The reasonable cost of meals actually incurred in transit will be reimbursed for the participant when

there is no other practical means of obtaining food. ()

b. The reasonable cost for lodging actually incurred for the participant will be reimbursed when: ()

i. The round trip and the needed medical service cannot be completed in the same day; and ()

ii. No less costly alternative is available. ()

c. The reasonable cost of wages for a non-family member attendant will be reimbursed when: ()

i. An attendant is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and ()

ii. No other unpaid attendant is available to accompany the participant. ()

d. The reasonable cost of meals actually incurred in transit will be reimbursed for one (1) family member or one (1) attendant, when: ()

i. Attendant care is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and ()

ii. There is no other practical means of obtaining food. ()

e. The reasonable cost of lodging actually incurred will be reimbursed for one (1) family member or one (1) attendant when: ()

i. An overnight stay is required to receive the service; ()

ii. It is medically necessary, or the vulnerability of the participant requires accompaniment for safety; and ()

iii. No less costly alternative is available. ()

343. NEMT SERVICES: REIMBURSEMENT METHODOLOGY.

The Department will reimburse the transportation broker a fixed, actuarially sound amount per member per month based on the cost of efficiently delivered, timely, and safe NEMT for eligible Idaho Medicaid participants and the cost for efficient administration of the brokerage program. ()

344. – 349. (RESERVED)

SUB AREA: EPSDT SERVICES
(Sections 350-359)

350. EPSDT SERVICES: DEFINITIONS.

01. Interperiodic Medical Screens. Screens done at intervals other than those identified in the American Academy of Pediatrics periodicity schedule. ()

02. Periodic Medical Screens. Screens done per the American Academy of Pediatrics periodicity schedule. ()

351. EPSDT SERVICES: PARTICIPANT ELIGIBILITY.

EPSDT services are available to participants from birth through the month of their twenty-first birthday. ()

352. EPSDT SERVICES: COVERAGE AND LIMITATIONS.

Services must be considered safe, effective, and meet acceptable standards of medical practice with the need for additional services documented by the screening provider as medically necessary. ()

01. Additional Services. Idaho Medicaid will cover services under the scope of the program as a result of an EPSDT screen regardless of inclusion in this rule or any existing amount, scope, and duration. Services must meet any applicable Department criteria and be prior authorized. ()

02. Interperiodic Screens. Interperiodic screens will be performed when indicated by medical necessity to determine whether a physical or mental illness or condition may require further assessment, diagnosis, or treatment. Interperiodic screens may occur for existing diagnoses when there is indication that the illness or condition may have changed sufficiently that further examination is medically necessary. ()

03. Eyeglasses Under EPSDT. ()

a. In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change. ()

b. The Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one (1) of these reasons on their claim. If repair costs are greater than the cost of new frames, new frames may be authorized. ()

353. (RESERVED)

354. EPSDT SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

Interperiodic and periodic medical screens must be performed by a physician, NP, or Physicians Assistant. ()

355. – 359. (RESERVED)

SUB AREA: SPECIFIC PREGNANCY-RELATED SERVICES
(Sections 360-369)

360. PREGNANCY-RELATED SERVICES: DEFINITIONS.

01. Individual and Family Social Services. Services directed at helping a participant to overcome social or behavioral problems that may adversely affect the outcome of the pregnancy. ()

02. Maternity Nursing Visit. Office visits by a licensed registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. ()

03. Nursing Services. Home visits by a licensed registered nurse to assess the participant's living situation and provide appropriate education and referral during the covered period. ()

04. Risk Reduction Follow-Up. Services to assist the participant in obtaining medical, educational, social, and other services necessary to assure a positive pregnancy outcome. ()

361. (RESERVED)

362. PREGNANCY-RELATED SERVICES: COVERAGE AND LIMITATIONS.

When ordered by the participant's attending provider, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs. ()

01. Individual and Family Social Services. Limited to two (2) visits during the covered period. ()

02. Maternity Nursing Visit. These services are only available to women unable to obtain a provider

to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. ()

03. Nursing Services. Limited to two (2) visits during the covered period. ()

04. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a PCP for the provision of antepartum care. ()

05. Risk Reduction Follow-Up. ()

363. (RESERVED)

364. PREGNANCY-RELATED SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Risk Reduction Follow-Up. A licensed social worker, RN, nurse midwife, physician, NP, or Physician's Assistant either in independent practice or as employees of entities that have provider agreements. ()

02. Individual and Family Social Services. A licensed social worker qualified to provide individual counseling. ()

365. PREGNANCY-RELATED SERVICES: PROVIDER REIMBURSEMENT.
A single payment will be made for each month of risk reduction follow-up services provided. ()

366. – 449. (RESERVED)

MEDICAID ENHANCED PLAN COVERED SERVICES
(Sections 450-979)

SUB AREA: ORGAN TRANSPLANTS
(Sections 450-459)

450. – 451. (RESERVED)

452. ORGAN TRANSPLANTS: COVERAGE AND LIMITATIONS.
The Department reimburses medically necessary organ transplant services when provided by CMS approved Medicare hospitals. ()

453. – 454. (RESERVED)

455. ORGAN TRANSPLANTS: REIMBURSEMENT.

01. General. Organ transplant, procurement services, and follow-up care by facilities are reimbursed as specified in the provider agreement. Payment for organ procurement and histocompatibility laboratory tests is made to the facility performing the transplant. ()

02. Living Donor Costs. Transplant costs for actual or potential living donors are fully covered by Medicaid and include all medically necessary preparatory, operation, and post-operation recovery expenses related to the donation. Payments for a donor's post-operation expenses are limited to the actual recovery period. ()

456. – 459. (RESERVED)

SUB AREA: PRIVATE DUTY NURSING (PDN)
(Sections 460-469)

460. PDN: DEFINITIONS.

01. Primary RN. An RN identified by the family who develops, implements, and maintains the Service Plan. ()

02. PDN RN Supervisor. An RN providing oversight of PDN delegated to LPNs providing a child's care. ()

03. PDN Services. Nursing services provided to a non-institutionalized child under age twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary and cannot be delegated to Unlicensed Assistive Personnel (UAP). ()

461. PDN: PARTICIPANT ELIGIBILITY.

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

01. Provider Ordered. ()

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

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

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

03. Service Plan. ()

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

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

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

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

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

462. PDN: LIMITATIONS.

PDN Services are provided only in a child's personal residence or when normal life activities take a child outside of the home. If PDN is requested only to attend school or activities out of the home, but the child does not need PDN at home, PDN is not authorized. Excluded residences include NFs, ICFs/IID, Residential Assisted Living Facilities, hospitals, and public or private schools. ()

463. (RESERVED)

464. PDN: PROVIDER QUALIFICATIONS AND DUTIES.

01. PDN Redetermination. The primary RN is responsible for submitting a current service plan to the

Department at least annually or as a child's needs change. Failure to submit an updated service plan prior to the end date of the most recent authorization will cause payments to cease until completed information is received and evaluated and authorization given for further PDN. ()

02. Physician Responsibility. Determine if the combination of PDN along with other community resources are sufficient to ensure the child's health or safety. If these resources do not ensure the child's health and safety, notify the family and the Department to facilitate the child's admission to an appropriate facility. ()

03. RN Responsibilities. RN supervisors or a provider of PDN must: ()

a. Notify the physician immediately of any significant changes in a child's medical condition or response to PDN; ()

b. Notify the Department within forty-eight (48) hours or on the first business day following a weekend or holiday of any significant changes in a child's condition or a child is hospitalized at any time; ()

c. Evaluate changes of condition; ()

d. Provide PDN under the PDN service plan; and ()

e. Ensure copies of records are maintained in the child's home including: ()

i. Service delivery date and start and end times; ()

ii. Comments on the child's response to PDN; ()

iii. Nursing assessment of child's status and any changes in status each shift; ()

iv. Services provided during each shift; and ()

v. Current signed Service Plan. ()

04. Oversight of LPNs. RN Supervisory visits occur at least once every thirty (30) days for PDN provided by an LPN. ()

465. – 469. (RESERVED)

SUB AREA: NURSING FACILITIES (NF)
(Sections 470-499)

470. NF: DEFINITIONS.

NF services include long term care services provided in a facility other than an institution for mental diseases (IMD). ()

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. ()

472. NF: PATIENT LIABILITY.

The Department reduces payment to the NF by each participant's patient liability as determined during the financial eligibility process. ()

473. NF: COVERAGE AND LIMITATIONS.

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

01. Minimum Coverage. Minimum services and supplies include: ()

a. Room and board; ()

b. Bed and bathroom linens; ()

c. Nursing care, including special feeding if needed; ()

d. Personal services; ()

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

f. Special diets prescribed by a physician; ()

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

h. Dressings. Applications using prescription medications or aseptic techniques must be completed by an RN; ()

i. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; ()

j. Application or administration of all drugs; ()

k. All common disposable medical supplies; ()

l. Social and recreational activities; and ()

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

02. Skilled Services. ()

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

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

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

03. Limitations. ()

a. Services requiring skilled nursing staff include: ()

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

ii. Nasopharyngeal feedings and aspiration; ()

iii. Tracheotomy aspiration; ()

iv. Catheter insertion, sterile irrigation, and replacement; ()

v. Treating extensive decubitus ulcers or other widespread skin disorders; ()

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

vii. Initial phases of a regimen involving oxygen administration. ()

b. Services requiring physical or occupational therapists include: ()

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

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

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

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

474. NF: PROCEDURAL RESPONSIBILITIES.

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

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

02. Changes of Resident's Income. ()

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

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

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

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

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

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

03. Change in Status. Resident reviews for residents with MI or DD must occur and a new determination made after any significant change in their physical or mental condition renders them incapable of responding to program interventions. NFs must notify the Department of any changes within two (2) working days of occurrence when any significant change requires new or increased specialized services. ()

476. NF: ELIGIBILITY COORDINATION AND SPECIALIZED SERVICE NEEDS.

When an individual identified with MI and DD is admitted to a NF, the NF must meet that individual's needs, except for specialized services. ()

01. Categorical Determinations. When NF level of care is determined categorical, an individual may be conditionally admitted prior to completion of a determination for specialized services. However, conditional admissions cannot exceed seven (7) days, except for respite admissions which cannot exceed thirty (30) consecutive days in a calendar year. ()

02. Specialized Services. Needs must be documented and included in both the resident assessment and service plan. ()

03. Non-Compliance Penalty. No payment is made for any services rendered by a NF prior to completion of a Level I screen and, if required, a Level II screen. ()

04. Appeals. A Level I determination of MI or ID is not appealable but may be disputed as part of a Level II determination appeal. ()

477. NF: PREPAYMENT SCREEN AND DETERMINATION OF ENTITLEMENT TO MEDICAID PAYMENT FOR NF CARE AND SERVICES.

A current Minimum Data Set (MDS) assessment is provided to the Department. Additional supporting information may be requested. In the event a required Level II screen was not completed prior to admission, entitlement for Medicaid payment is not earlier than the date of Level II screen completion, indicating NF placement is appropriate. ()

478. NF: PROVIDER QUALIFICATIONS AND DUTIES.

01. Application. ()

02. Licensure and Certification (L&C). ()

a. Upon receipt of a NF application, the State determines compliance with certification standards for the type of care the NF proposes to provide to Medicaid participants. ()

b. NFs applying to participate as a Skilled Nursing Facility must meet Medicare certification and program participation requirements before Medicaid certification. The State determines NF compliance with Medicare and recommends certification to the Medicare Agency. ()

c. The Department certifies to the appropriate branch of government when the State determines a NF meets certification standards for NF care. ()

479. – 480. (RESERVED)

481. NF: COST LIMITS.

The Idaho Medicaid Provider Agreement Additional Terms – Nursing Facility provides requirements necessary to implement the provisions and accomplish the objectives of the NF reimbursement system. ()

482. NF: RATE SETTING.

01. Payments. Payments to NFs through a prospective price-based system, which includes NF-specific case mix adjustments, separate margin payments for indirect care costs and direct care costs, and applied BAF. ()

02. Rate Adjustment. To set rates based on each NF's CMI on a quarterly basis and establish rates reflecting the case mix of each NF's Medicaid residents as of a certain date during the prior quarter. ()

483. NF: PRINCIPLE FOR RATE SETTING.

Rates are set based on projected cost data from cost and audit reports for freestanding and hospital-based NFs. In general, methodology uses a cost-based prospective reimbursement system with an acuity adjustment for direct care costs, allowances for margin payments related to indirect and direct care costs, and subject to the application of a BAF. ()

484. NF: RATE DEVELOPMENT.

NF rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly case mix adjustments. In no case will a rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. Rates are calculated using audited cost reports for the periods ending in the calendar year two (2) years prior to each July 1, including inflation adjustments from the midpoint of the cost report period to the mid-point of a rate period, except for property costs. ()

485. NF: OUT-OF-STATE FACILITIES.

Medicaid reimburses for out-of-state NF placements when services are not available in Idaho to meet the medical need, or in temporary situations for safe transportation to an Idaho NF. Services are paid the per diem rate, except where noted, for the state where the NF is located. ()

486. NF: DISTRESSED FACILITY.

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

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

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

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

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

d. The determination of distressed status focuses on whether the NF's distress stems from patient care costs, and not expenses unrelated to patient care costs. ()

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

process up to the federal UPL. ()

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

04. Prospective Application. Only NFs currently distressed or entering a period of distress are eligible. ()

487. NF: REVIEWS.

01. Facility Review. The Department may send information for NF review for rate setting. The NF must confirm its accuracy in writing or communicate errors to the Department with supporting documentation. If nothing is provided, the Department may rely on other available information for rate setting. Once information is used to set rates, it is considered final unless modified by subsequent Department review. ()

02. Department Review. The Department may retroactively adjust a NF's rate for incorrect information and calculate an overpayment. Adjustments do not include residents who received a default classification due to incomplete or inconsistent MDS data. ()

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

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

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

489. NF: BCU QUALIFICATIONS.

Facilities must meet the qualifications for a BCU described in the Idaho Medicaid Provider Agreement Additional Terms – Behavioral Care Units. ()

490. NF: BCU ELIGIBLE DAYS.

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

491. NF: SPECIAL RATES.

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

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

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

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

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

05. Prospective Rate Treatment. Special rates are paid under a prospective payment system. ()

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

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

b. The Department pays for equipment and non-therapy supplies not addressed in the coverage and limitations section in accordance with DMEPOS, as an add-on amount. ()

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

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

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

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

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

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

492. NF: OCCUPANCY ADJUSTMENT FACTOR.

The Department makes adjustments to equitably allocate fixed costs for patients when a NF fails to maintain reasonable occupancy levels. No occupancy adjustment is made against costs used to calculate a property rental rate. Adjustments are made against all other property costs: ()

01. Occupancy Levels. If a NF maintains an average occupancy of less than eighty percent (80%) of capacity, the total property costs not including cost paid under a property rental rate, are prorated based upon an eighty percent (80%) occupancy rate. A NF's average occupancy percentage is subtracted from eighty percent (80%) and the result is multiplied by the total fixed costs to determine nonallowable fixed costs. When a NF changes designed capacity, average occupancy for the period before and after the change is computed for each period. ()

02. Occupancy Adjustment. NF capacity is computed based on the greater of the largest number of beds under a NF's license during the reporting period, except when a portion of the NF was converted to use for non-routine NF activities, or a newly constructed facility enters the Medicaid Program. If a NF's designed capacity changes, the number of beds used to determine occupancy is lowered by the capacity amount converted to non-routine NF activities. New NF capacity is based on the number of beds approved by the certificate of need process minus any capacity converted to non-routine NF activities. ()

03. Fixed Costs. Occupancy adjustments to fixed costs are considered allowable and reimbursable costs when reported under property cost categories. ()

04. Adjustment Exemption. An increase in number of beds and new NFs are not subject to an adjustment for the first six (6) months of licensure or operation. ()

493. NF: RECAPTURE OF DEPRECIATION.

When depreciable assets reimbursed by Medicaid based on cost are sold for an amount exceeding their net book value, depreciation is recaptured from the NF buyer in an amount equal to reimbursed depreciation or gain on the sale, whichever is less. ()

01. Amount Recaptured. Depreciation is recaptured in full when a sale of a depreciated NF occurs within the first five (5) years of ownership. For every year an asset is held beyond the first five (5) years, total depreciation recaptured is reduced by ten percent (10%) per year. ()

02. Time Frame. The Department recaptures depreciation from a NF buyer over no more than five (5) years from the sale date, with no less than one-fifth (1/5) of the total recaptured amount for each year after. ()

494. NF: NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS (NATCEPS).

NATCEP costs are outside the content of NF care and must be reported by all NFs. Costs are reported separately as exempt costs and not included in the percentile cap. ()

495. NF: PAYMENTS FOR TEMPORARY ABSENCES.

Limitations for payments made to reserve beds in NFs during a temporary absence if the NF charges private pay patients for reserve bed days: ()

01. NF Occupancy Limits. Payment for temporary absences from NFs are made according to the number of licensed and unoccupied beds. ()

a. Payments are not allowed for NFs with less than one hundred (100) licensed beds when five (5) or more are unoccupied. ()

b. Payments may be allowed for NFs with one hundred (100) or more licensed beds when the minimum occupancy rate is ninety-five percent (95%). ()

02. Time Limits. Payments for temporary absences are made for therapeutic home visits for residents up to three (3) days per visit, not exceeding fifteen (15) days per calendar year for days included as part of a treatment plan ordered by a provider. ()

03. Payment Limits. Reserve bed days payments are the lesser of seventy-five percent (75%) of the audited allowable NF costs or the rate charged to private pay residents. ()

496. – 499. (RESERVED)

SUB AREA: ICF/IID
(Sections 500-529)

500. (RESERVED)

501. ICF/IID: PARTICIPANT ELIGIBILITY.

Approval for services will be no earlier than the medical provider's signed and dated certification for ICF/IID level of care. ()

01. Required Information for Applications. ()

a. A complete and current medical examination within ninety (90) days of admission, signed and dated by a medical provider, primary and secondary diagnoses, medical findings and history, mental and physical

functional capacity, prognosis, mobility status, and medical provider's statement certifying ICF/IID level of care is needed. ()

b. An initial plan of care current within ninety (90) days of admission, signed and dated by a medical provider, and includes orders for medications and treatments, diet, and professional rehabilitative and restorative services and special procedures, when needed. ()

c. A social evaluation current within ninety (90) days of admission, that includes condition at birth, age at onset of condition, summary of functional status, such as skills level, ADL, and family social information. ()

d. A psychological evaluation conducted by a provider current within ninety (90) days of admission, or infants under three (3) years old may be evaluated by a DD specialist using developmental milestones congruent with the infant's age. Evaluations include diagnosis, summary of developmental findings, mental and physical functioning capacity, and recommendations for placement and primary need for active treatment. ()

e. An initial plan of care developed by the admitting ICF/IID. ()

02. ICF/IID Eligibility Criteria. ()

a. Individuals with a primary DD diagnosis or a related condition and qualify based on functional limitations, maladaptive behavior, a combination of both, or medical condition significantly affects their functional level/capabilities. ()

b. Individual requires and receives intensive inpatient active treatment to advance or maintain their functional level. Active treatment does not include parenting activities directed toward the acquisition of age-appropriate developmental milestones, interventions that address age-appropriate limitations, or general supervision required by all children of the same age. The following criteria evaluate the need for active treatment: ()

i. Complete medical, social, and psychological evaluations that clearly indicate the functional level of the participant and interventions needed; and ()

ii. A written plan of care with initial goals and objectives, specifying further evaluations required, and training programs to be developed. ()

c. Individual requires the level of care provided in an ICF/IID, including active treatment, and, in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an IMD. ()

d. ICF/IID level of care is redetermined annually related to continued need of community services. ()

i. Home Care for Certain Disabled Children receive services until the end of the month their redetermination was made. When the redetermination is made less than ten (10) days from the end of a month, payment continues until the end of the following month. ()

ii. Individuals receiving DD waiver services have thirty (30) days from the determination to transition to other community supports. ()

502. ICF/IID: COVERAGE AND LIMITATIONS.

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

01. Coverage. The minimum content of care and services for ICF/IID residents includes: ()

a. Room and board; ()

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

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

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

503. ICF/IID: PROCEDURAL RESPONSIBILITIES.

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

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

02. Annual Recertification. ICF/IIDs must assure that participant annual recertifications are completed. ()

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

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

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

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

504. ICF/IID: PROVIDER QUALIFICATIONS AND DUTIES.

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

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

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

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

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

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

505. ICF/IID: REIMBURSEMENT.

These rules do not apply to ICF/IID facilities owned or operated by the state of Idaho. ICF/IIDs are reimbursed per patient day with the ICF/IID methodology implemented by the Department. ()

506. (RESERVED)

507. ICF/IID: ALLOWABLE COSTS.

01. Auto and Travel Expense. ()

02. Bad Debts. ()

03. Bank or Finance Charges. ()

04. Compensation of Owners. ()

05. Contracted Service. ()

06.	Depreciation.	()
07.	Dues, Licenses, or Subscriptions.	()
08.	Employee Benefits.	()
09.	Employee Recruitment.	()
10.	Entertainment Costs Related to Patient Care.	()
11.	Food.	()
12.	Home Office Costs.	()
13.	Insurance.	()
14.	Interest.	()
15.	Lease or Rental Payments.	()
16.	Malpractice or Public Liability Insurance.	()
17.	Payroll Taxes.	()
18.	Principle. Costs for services, facilities, and supplies furnished to the provider by organizations or persons related to a provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable when they relate to care, are reasonable, ordinary, and necessary, and do not exceed costs incurred by a prudent cost-conscious buyer.	()
19.	Property Costs.	()
20.	Property Insurance.	()
21.	Repairs or Maintenance.	()
22.	Salaries.	()
23.	Supplies.	()
24.	Taxes.	()
508.	ICF/IID: NON-ALLOWABLE COSTS.	
01.	Accelerated Depreciation.	()
02.	Acquisitions.	()
03.	Charity Allowances.	()
04.	Consultant Fees.	()
05.	Franchise Fees.	()
06.	Fund Raising.	()
07.	Goodwill.	()

08.	Holding Companies.	()
09.	Interest to Finance Unallowable Costs.	()
10.	Medicare Costs.	()
11.	Non-patient Care Related Activities.	()
12.	Organization.	()
13.	Pharmacist Salaries.	()
14.	Prescription Drugs.	()
15.	Related Party Interest.	()
16.	Related Party Non-allowable Costs.	()
17.	Related Party Refunds.	()
18.	Self-Employment Taxes.	()
19.	Vending Machines.	()

509. (RESERVED)**510. ICF/IID: OCCUPANCY ADJUSTMENT FACTOR.**

Adjustments are to equitably allocate fixed costs for Medicaid patients when a facility falls below reasonable occupancy levels. No occupancy adjustment is made against costs used to calculate the property rental rate. Adjustments are made against all other property costs: ()

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of capacity, the total property costs not including cost paid for property rental rate, is prorated based on an eighty percent (80%) occupancy rate. A facility's average occupancy percentage is subtracted from eighty percent (80%) and the resultant percentage is multiplied by the total fixed costs to determine non-allowable fixed costs. When a provider changes the designed capacity, the average occupancy for the period before and after the change is computed for each period. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. ()

02. Occupancy Adjustment. Facility capacity is computed based on the greater of the largest number of beds a facility was licensed for during the reporting period or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed. If a facility's designed capacity changes, the number of beds used to determine occupancy is lowered by the capacity amount converted to non-routine ICF/IID activities. The new capacity is based on the number of beds approved by the certificate of need process less any capacity converted to non-routine ICF/IID activities. ()

03. Fixed Costs. Occupancy adjustment to fixed costs is considered allowable and reimbursable when reported under property cost categories. ()

04. New Facility. For newly licensed and occupied facilities, the first six (6) months occupancy level is not subject to an adjustment. ()

511. ICF/IID: RECAPTURE OF DEPRECIATION.

Depreciable assets reimbursed based on cost, and sold for an amount over net book value, are recaptured from the facility's buyer in an amount equal to reimbursed depreciation, or gain on the sale, whichever is less. ()

01. Amount Recaptured. Depreciation is recaptured in full when sale of a depreciated facility occurs within the first five (5) years of ownership. For every year an asset is held beyond the first five (5) years, total depreciation recaptured is reduced by ten percent (10%) per year. ()

02. Time Frame. The Department recaptures depreciation from the facility buyer over no more than five (5) years from the sale date, with no less than one fifth (1/5) of the total amount recaptured each year after. ()

512. ICF/IID: REPORTING SYSTEM.

A uniform system of periodic reports is used to allow: ()

01. Basis for Reimbursement. By approximating actual costs. ()

02. Adequate Financial Disclosure. ()

03. Statistical Resources. As a basis for measuring reasonable costs and comparative analysis. ()

04. Criteria For Evaluating Policies and Procedures. ()

513. ICF/IID: REPORTING SYSTEM PRINCIPLE AND APPLICATION.

Providers must file annual cost reports. ()

01. Cost Report Requirements. The fiscal year end filings include: ()

a. Annual income statement; ()

b. Balance sheet; ()

c. Statement of ownership; ()

d. Schedule of patient days; ()

e. Schedule of private patient charges; ()

f. Statement of additional charges to residents above usual monthly rates; and ()

g. Other schedules, statements, and documents as requested. ()

02. Special Reports. When required, specific instructions are issued, based upon the circumstance. ()

03. Report Criteria. ()

a. Use of State-approved formats. ()

b. Presented on accrual basis. ()

c. Prepared according to GAAP and principles of reimbursement. ()

d. Providing appropriate detail on supporting schedules or as requested. ()

04. Preparer. Statements do not require a CPA. ()

05. Reporting by Chain Organizations or Relative Providers. Filing combined or consolidated cost reports as a basis for reimbursement is prohibited. Each facility must file a separate set of reports for each level of organization allocating expenses to a provider. Consolidated financial statements are considered supplementary

information and do not meet primary reporting requirements. ()

06. Change of Management or Ownership. To properly pay separate entities or individuals after a change of management or ownership, the following requirements apply: ()

a. Outgoing management or administration must file an adjusted-period cost report when necessary. This report will meet the criteria for annual cost reports and be filed no later than sixty (60) days after the change. ()

b. The Department may require an appraisal for a change in ownership. ()

07. Reporting Period. When required to establish rates, new ICF/IIDs are required to submit cost projections for the first year of operations. Thereafter, the normal reporting period coincides with the facility's standard fiscal year. If a facility withdraws from the program and later re-enters, new provider reporting requirements apply. ()

514. (RESERVED)

515. ICF/IID: PRINCIPLE PROSPECTIVE RATES.

ICF/IID are paid a per diem rate that, with certain exceptions, is not subject to audit settlements. The rate for a fiscal period is based on audited historical costs not adjusted for inflation. Facilities must report these costs. Total payments include property reimbursement, capped costs, exempt costs, and excluded costs. Rates are calculated using audited cost reports for the calendar year two (2) years prior to July 1st, with no cost or cost limit adjustments for inflation. ()

516. ICF/IID: PROPERTY REIMBURSEMENT.

ICF/IID property costs are reimbursed using a rental rate or based on cost. The following are reimbursed based on cost under these rules and PRM: ICF/IID living unit property taxes, living unit property insurance, and major movable equipment not related to home office or day treatment services. Reimbursement of other property costs is included in the property rental rate. Any property cost related to home offices and day treatment services are not considered property costs and are not reported in the property cost portion of the cost report. These costs are reported in the home office and day treatment section of the cost report. Property costs, including costs reimbursed based on a rental rate, are reported in the property cost portion of the cost report. The Department may require and use an appraisal to establish those components identified as an integral part of an appraisal. Property costs include the following allowable components: ()

01. Straight-Line Depreciation. ()

02. Interest. ()

03. Property Insurance. ()

04. Lease Payments. ()

05. Property Taxes. ()

06. Costs of Related Party Leases. ()

517. ICF/IID: CAPPED COST.

01. Costs Subject to the Cap. Include all allowable costs except property costs under property reimbursement and exempt excluded costs. ()

02. Per Diem Costs. Costs are divided by total resident days for a facility in the cost reporting period to arrive at allowable per diem costs. If costs for services provided any non-Medicaid residents are not included in the total costs submitted, the facility must determine these costs and combine them with submitted costs so a total per diem cost for that facility is determined for both determining the ICF/IID cap and computing final reimbursement.

()

03. Cost Data to Determine the Cap. Cost data from the final cost report used for rate setting, per prospective principles, will be used. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. However, the final cost reports covering a period of less than twelve (12) months are included in data to determine the cap at the option of the Department.

()

04. Payments to Non ICF/IIDs. Payments made by the Department directly to non-ICF/IIDs are excluded from the ICF/IID prospective rates and cap. Services covered under EPSDT or “Medicaid Basic Plan Benefits” are not included in ICF/IID costs. Providers must bill Medicaid directly for these services under their own provider number.

()

05. Cost Ranking. Prior to annual rate setting, the Director will determine the percent above the median used in the cap calculation. That percent will apply to the cap and rates set per prospective principles. Per diem capped costs, by facility, as determined in this section will be ranked from the highest to the lowest, with the median being the 50th percentile. The cap for the applicable rate period will not exceed the 75th percentile of these ranked per diems.

()

a. The median of the range is computed based on the available data points considered the total population of data points.

()

b. A new cap and rate are set annually for each facility July 1st.

()

c. The cap and prospective rate are determined and set annually for each facility July 1st and is not changed by any subsequent events or information unless the computations are found to contain mathematical or clerical errors. These errors are then corrected, and the cap is adjusted using corrected figures.

()

d. Payment of costs subject to the cap are limited to the cap unless the Department determines the exclusions.

()

518. (RESERVED)

519. ICF/IID: RETROSPECTIVE SETTLEMENT.

When applicable, settlements are based on allowable reimbursement under these rules, based on an audit report, and subject to the same caps and limits determined for prospective payments.

()

01. Failure to Meet Conditions.

()

02. First Time Provider.

()

03. New ICF/IID Living Unit.

()

04. Ownership Change.

()

05. Fraudulent Claims.

()

06. Excluded Costs.

()

520. ICF/IID: EXEMPT COSTS.

Day treatment services and major movable equipment costs are not subject to the ICF/IID cap.

()

521. ICF/IID: COSTS EXCLUDED FROM CAP.

Certain costs excluded from the ICF/IID cap are subject to retrospective settlement at the discretion of the Department, and result in changes to a prospective rate to assure equitable reimbursement:

()

01. Increases to Per Participant Day Costs.

()

- 02. Excess Inflation. ()
- 03. Cost Increases Over 3%. ()
- 04. Decreases. ()
- 05. Prospective Negotiated Rates. ()

522. (RESERVED)

523. ICF/IID: PROPERTY RENTAL RATE REIMBURSEMENT.

ICFs/IID are paid a property rental rate. Property taxes, property insurance, depreciation expense, and major moveable equipment are reimbursed as costs exempt from limitations. The property rental rate does not include compensation for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. ()

01. **Rate Calculation.** Property rental rates are based upon current construction costs, age of a facility, type of facility, and major expenditures made to improve a facility, or a rate based upon current property costs. Amounts paid for each Medicaid day of care are phased in as follows: ()

a. “R” = “Property Base” x forty (40) - “Age” / forty (40) x “change in building costs” where: ()

b. “R” = the property rental rate. ()

c. “Property Base”: ()

i. Eleven dollars and twenty-two cents (\$11.22) for ICF/IID with wheelchair accommodations. ()

ii. Seven dollars and twenty-two cents (\$7.22) for ICF/IID without wheelchair accommodations. ()

d. “Change in building costs” = the most recent CMI available to set a prospective rate for a period including all or part of the calendar year. ()

e. “Age” of facility = The effective age of the facility in years is set by subtracting the year in which a facility, or a new section, was constructed from the year in which the rate is applied. No facility or new section is assigned an age over thirty (30) years, however: ()

i. The age is set at thirty (30) years unless documentation is received to the contrary. Adequate documentation includes, but is not limited to, copies of building permits, tax assessors' records, receipts, invoices, building contracts, and original notes of indebtedness. An age is determined for each building. A weighted average using the age and square footage of the buildings becomes the effective age of a facility. The age of each building is based upon the date when construction on that building was completed. ()

ii. An effective age of a facility is further adjusted when the cost of major repairs, replacements, remodeling, or renovation of a building results in a change in age by at least one (1) year when applied to this formula:

$$r = A \times E / S \times C$$

Where:

r	=	Reduction in the age of a facility in years.
A	=	Age of a building at the time construction was completed.

E	=	Actual expenses for construction provided the total costs were incurred within 24 months of completion of the construction.
S	=	The number of square feet in a building at the end of construction.
C	=	The cost of construction for buildings in the year construction was completed.

These changes do not decrease an effective age of a facility beyond the point where an increase in the property rental rate is more than three fourths (3/4) of the difference between the property rental rate “r” for a new facility at the time of a proposed rate revision and the property rental rate a facility was eligible for immediately before an adjustment. The cost for “C” is adjusted according to costs published by Marshall Swift Valuation Service reflecting current construction costs for average Class D convalescent hospitals. Providers must notify the Department with documented costs. The Department adjusts the age. ()

iii. The Department reimburses expenditures directly related to new requirements imposed by state or federal agencies, as an increase to the property rental rate if the expense exceeds one hundred dollars (\$100) per bed. When costs related to a requirement are less than one hundred dollars (\$100) per bed, the Department reimburses the Medicaid share of the entire cost of new requirements in a one-time payment to a facility within twelve (12) months of expense verification. ()

iv. “Age of facility” will be a revised age that is lesser of either the age established under this section, or the age that most closely yields the rate allowable to existing facilities. This revised age will not increase over time. ()

02. Facility Sale. When a facility, or asset of a facility, is sold, the buyer receives the property rental rate as calculated. ()

524. ICF/IID: PROPERTY REIMBURSEMENT LIMITATIONS.

Property costs of an ICF/IID are reimbursed except as follows: ()

01. Property Leases. No grandfathered rates or lease provisions other than the following apply: ()

a. Property costs related to living units other than costs for major movable equipment are paid the property rental rate. ()

b. Leases for property other than ICF/IID living units are allowable based on lease cost to a facility not exceeding reasonable market rate, subject to principles associated with related party leases. ()

02. Home Office and Day Treatment Property Costs. Distinct parts of buildings containing ICF/IID living units may be used for home office or day treatment purposes. Reimbursement for the property costs of these parts is allowed when the areas are used exclusively for these services. The portion of property cost attributed to these areas is reimbursed as part of home office or day treatment costs without a reduction in the property rental rate. Reimbursement for these costs does not include costs reimbursed by, or covered by the property rental rate, and are only reimbursed as property cost when the facility clearly included space in excess of space normally used in a facility. To qualify for reimbursement, a structure must have square feet per licensed bed exceeding the average square feet per licensed bed for other ICF/IID living units with four (4) licensable beds. ()

525. ICF/IID: SPECIAL RATES.

The Department pays special rates for care for residents with long-term medical or behavioral care needs beyond the normal scope of facility services. Payment for specialized care is in addition to any payments made under these rules and based on a per diem rate applicable to the incremental additional costs incurred by a facility. Incremental costs to a facility exceeding the rate for services provided are excluded from the computation of payments. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits and will be reported separately. Special rates are determined on an individual basis, must be prior authorized by the Department, and may be used in one (1) of the following circumstances: ()

- 01. New Admissions to a Community ICF/IID.** ()
- 02. Significant Change in Condition.** Residents of a community ICF/IID experiencing a significant change in condition not reflected in their current rate. ()
- 03. Altered Services.** A facility altered services to achieve or maintain compliance with state or federal requirements resulting in additional costs not reflected in their current rate. ()
- 04. Emergency.** An emergency exists when a facility must incur additional behavioral or medical costs to prevent more restrictive placements. ()

526. – 529. (RESERVED)

SUB AREA: HOME AND COMMUNITY-BASED SERVICES (HCBS)
(Sections 530-539)

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. ()

532. (RESERVED)

533. HCBS: PROVIDER QUALIFICATIONS AND DUTIES.

Providers must develop and implement policies and procedures to address the HCBS setting requirements. ()

534. (RESERVED)

535. EXCEPTIONS TO RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.

Exceptions to residential setting requirements must be based on a participant's needs identified through person-centered planning. Service plans with exceptions must be submitted to the Department or its designee for review and

approval. ()

536. HCBS PERSON-CENTERED PLAN REQUIREMENTS.

In addition to federal requirements, legal guardians without full decision-making authority hold a participatory role as identified by the participant. ()

01. Setting Selection. Identify and document the alternative HCBS options considered by the participant, or the participant's decision-making authority. ()

02. Plan Signatures. The plan must also be signed by the plan developer and all individuals and providers responsible for its implementation. ()

03. Residential Requirements. Any exception to residential provider-owned or controlled setting qualities must be documented in the person-centered plan. ()

537. – 538. (RESERVED)

539. HCBS: PARTICIPANT ELIGIBILITY.

01. Federal and State Eligibility Requirements. To be enrolled in an HCBS waiver or State Plan option program, a participant must meet the following eligibility requirements: ()

a. An independent assessment; ()

b. A state-approved person-centered plan; ()

c. Annual eligibility redetermination; and ()

d. Other state-established criteria for determining Medicaid eligibility. ()

02. Failure to Meet Requirements. A participant who does not meet eligibility criteria is subject to termination of enrollment. ()

03. Conditions for Termination. The Department will terminate participant enrollment if they: ()

a. Do not have an identified need for a waiver or State Plan option service; ()

b. Elect not to use services offered under the HCBS waiver or State Plan option; ()

c. Decline to engage in person-centered planning; ()

d. Do not meet other HCBS eligibility requirements; or ()

e. Are non-responsive to three or more contact attempts by the Department or its designee. ()

04. Continuous Eligibility for Children Under Age Nineteen. Continuous health care assistance eligibility for children under age nineteen (19), as provided in IDAPA 16.03.01, does not apply for a participant under the age of nineteen (19) who is enrolled in an HCBS waiver or State Plan option program or who has accessed Medicaid coverage through an HCBS waiver or State Plan option program. ()

**SUB AREA: AGED AND DISABLED (A&D) WAIVER SERVICES
(Sections 540-548)**

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.* ()

541. A&D WAIVER SERVICES: ELIGIBILITY.

The number of Medicaid participants to receive waiver services under the A&D HCBS waiver is limited to the projected number of users identified in the Department's approved waiver. Participants who apply for waiver services after the waiver maximum is reached are placed on a waiting list and will have their applications processed after the new waiver year begins. The earliest waiver approval date for these participants is the first date of a new waiver year. Participants are eligible when they meet the following criteria: ()

01. Age. Are eighteen (18) years of age or older. ()

02. Disabling Condition. Have a disabling condition that impairs their mental or physical function or independence; ()

03. Non-Institutional Setting. Can be maintained safely and effectively in a non-institutional setting; ()

04. Require Services. In the absence of such services, require the level of care provided in a NF; ()

05. Average Daily Cost. Cannot exceed the participant's waiver and other medical services for the average daily cost of NF care; ()

06. Non-Use. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program unless services were inaccessible; and ()

07. Admission to a NF. A participant determined by the Department to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to a NF. ()

08. NF Level of Care, Adults. Based on assessment results, the level of impairment of an individual is established by the Department. ()

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

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

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

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

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

03. Specialized Medical Equipment and Supplies. ()

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

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

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

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

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

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

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

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

10. Homemaking Services. Performing for or assisting the participant with essential errands and other routine housekeeping duties when no one else in the household is capable of performing these tasks. ()

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

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

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

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

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

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

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

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

a. Self-direction; ()

b. Money management; ()

c. Daily living skills; ()

d. Socialization not including participation in non-therapeutic activities that are diversional or recreational in nature; ()

e. Mobility; ()

- f.** Behavior shaping and management. ()
- g.** Personal assistance services that assist an individual in ADL, household tasks, and other routine activities as the participant or their primary caregivers are unable to accomplish on their own behalf. ()
- h.** Skills training to teach participants and supports to perform activities with greater independence and to reinforce habilitation training. ()
- 16. Day Habilitation.** Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting. Services focus on enabling the participant to attain or maintain their maximum functional level and are coordinated with any physical, occupational, or speech-language therapy services listed in the plan of care. Services may reinforce skills taught in school, therapy, or other settings. ()
- 17. Supported Employment.** Competitive work in integrated work settings for individuals for whom competitive employment has not traditionally occurred, or when competitive employment is interrupted or intermittent due to severe disability. The nature and severity of an individual's disability requires intensive supported employment services or extended services for them to work. This service is not available when funded under another program. ()
- 18. Transition Services.** Goods and services enabling a participant residing in a NF, hospital, IMD, or ICF/IID to transition to a community-based setting immediately following discharge from a qualified institution after a minimum of forty-five (45) days. ()

 - a.** Services may include: ()

 - i. Security deposits required to obtain a lease on an apartment or home; ()
 - ii. Cost of essential household furnishings; ()
 - iii. Set-up fees or deposits for utility or service access; ()
 - iv. Services necessary for health and safety prior to occupancy; ()
 - v. Moving expenses; and ()
 - vi. Activities to assess need, arrange for, and procure transition services. ()
 - b.** Exclusions. Ongoing expenses (including utilities), real property, décor, or entertainment and recreational items. ()
 - c.** Limitations. A total cost of two thousand dollars (\$2,000) per participant and only accessed every two (2) years, following a qualifying transition. Services are furnished when a participant is unable to meet an expense or when a support cannot be obtained from other sources. ()
- 19. A&D Case Management.** To assist participants with gaining and coordinating access to necessary care and services appropriate to the needs of the individual. ()

543. A&D WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

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

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

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

c. All services that are provided must be based on a documented service plan. ()

d. A new plan must be developed and approved annually. ()

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

02. Provider Records. ()

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

i. Service date; ()

ii. Services provided; ()

iii. Statement of participant's response to services when applicable, including any changes in their condition; and ()

iv. Length of visit, including time in and out. Unless the Department determines a participant is unable to, service delivery is verified by the participant by signing a service record. ()

b. Providers must maintain service delivery records accessible to participants. ()

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

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

03. Provider Notification. Providers must document in the service record and notify the Department, medical provider, case manager, and family when any significant changes in the participant's condition are noted. ()

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

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

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

a. Assure compliance with legal requirements related to employment of providers; ()

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

c. Bill Medicaid for services authorized by the Department; ()

- d.** Collect any participant participation due; ()
 - e.** Pay providers for service; ()
 - f.** Perform all necessary withholding as required by state and federal regulations; ()
 - g.** Assure that providers meet the required standards and qualifications; ()
 - h.** Maintain liability insurance coverage; ()
 - i.** Conduct annual participant satisfaction or quality control reviews made available to the Department and the public; and ()
 - j.** Obtain required background checks and health screens on employees. ()
- 03. Provider Qualifications.** Providers of homemaker, respite care, ADH, transportation, chore services, companion services, attendant care, adult residential care, A&D Case Management, and home-delivered meals must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's A&D waiver as approved by CMS. Direct care workers cannot be a participant's spouse. ()
- 04. Quality Assurance (QA).** Providers must respond to QA reviews within forty-five (45) days of receiving results. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. ()
- 05. Specialized Medical Equipment and Supplies.** Must be enrolled with Medicaid as a supplier. Providers must ensure all items meet applicable standards of manufacture, design, and installation. Preference is given to the most cost-effective option to meet a participant's needs. ()
- 06. Consultation Services.** Must be provided through a PAA by a person with demonstrated skills in training participants/family members to hire, fire, train, and supervise their own care providers. ()
- 07. Adult Residential Care.** Must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. ()
- 08. Home-Delivered Meals.** ()
- a.** Each meal meets one third (1/3) of the Recommended Daily Allowance, as defined by the United States Department of Agriculture (USDA); ()
 - b.** Meals are delivered under the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; ()
 - c.** Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; and ()
 - d.** A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions. ()
- 09. PERS.** Must demonstrate that devices installed in a participant's home meet Federal Communications Commission (FCC) standards. ()
- 10. Adult Day Health.** ()
- a.** Providers must notify the Department for the participant when the service is provided in a CFH other than the participant's primary residence. ()

- b.** Providers must be free from communicable disease. ()
- 11. Non-Medical Transportation.** Possess a valid driver's license and vehicle insurance. ()
- 12. Attendant Care.** Must be employees of an agency. ()
- 13. Homemaker Services.** Must be employees of an agency. ()
- 14. Environmental Accessibility Adaptations.** Must meet applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. ()
- 15. Residential Habilitation.** Employment by a certified residential habilitation agency. Prior to delivering services, complete an orientation program and additional training requirements must be completed within six (6) months of employment. ()
- 16. Day Habilitation.** Employed by a certified residential habilitation agency. Prior to delivering services, staff must complete an orientation program and complete additional training within six (6) months of employment. ()
- 17. Respite Care.** Receive instructions in the participant's needs, demonstrate the ability to follow the service plan, and be free of communicable disease. ()
- 18. Supported Employment.** Provided by an agency that meets State requirements. ()
- 19. Chore Services.** Be skilled in the service to be provided; and demonstrate the ability to follow a service plan. ()
- 20. Transition Services.** Transition managers. ()
- 21. A&D Case Management.** Case Managers must be employed by an agency that is not an FI. Case Managers may not provide other services. ()
- 545. A&D WAIVER SERVICES: PROVIDER REIMBURSEMENT.**
- 01. Rates.** Reimbursement for services include both services and mileage. Mileage for provider transportation to and from the service delivery location is not reimbursable. ()
- 02. Electronic Visit Verification (EVV) Compliance.** Claims for Attendant Care, Homemaker, and Respite services require EVV compliance to be reimbursable. ()
- 546. – 548. (RESERVED)**

SUB AREA: TRANSITION MANAGEMENT
(Section 549)

549. TRANSITION MANAGEMENT.

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

- 01. Provider Qualifications.** Transition managers must: ()
- a.** Successfully complete of a Department-approved Transition Manager training prior to providing any transition management or transition services; ()

- SUB AREA: PERSONAL CARE SERVICES (PCS)**
(Sections 550-559)

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

any time. ()

552. PCS: COVERAGE AND LIMITATIONS.

01. Medical Care and Services. Tasks related to a participant's physical or functional requirements provided in the participant's personal residence including assistance with: ()

a. Basic personal care and grooming; ()

b. Bladder or bowel routines or requirements; ()

c. Food, nutrition, and diet activities; ()

d. Continuation of at home active treatment programs to increase or maintain independence for participants with DD; ()

e. Physician-ordered medications ordinarily self-administered; ()

f. Non-nasogastric gastrostomy tube feedings that meet the following requirements: ()

i. Non-complex tasks that can be safely performed in a participant's location; ()

ii. An RN assessed a participant's needs and developed a written procedure according to a participant's individualized needs; ()

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

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

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

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

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

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

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

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

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

04. Service Exclusions. ()

a. Irrigating or suctioning any body cavity requiring sterile procedures or applying dressings with

prescription medication or aseptic techniques; ()

b. Catheter insertion or sterile irrigation; ()

c. Injecting fluids into veins, muscles or skin; and ()

d. Administering medication not authorized by a supervisor RN. ()

05. Participant Limitations. Sixteen (16) hours per week unless authorized under EPSDT. ()

06. Provider Limitations. No home, regardless of the number of providers in a home, may serve more than two (2) children authorized for eight (8) or more hours of PCS per day. ()

553. PCS: PROCEDURAL REQUIREMENTS.

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

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

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

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

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

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

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

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

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

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

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

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

c. Providers must sign the service plan indicating they will deliver services according to the authorization and consistent with HCBS requirements. ()

d. EVV systems described do not replace documentation requirements but may be used to generate

documentation. ()

05. Provider Notification. Providers must notify the Department and the medical provider for any significant changes in a participant's condition occur, and document in the participant record. ()

554. PCS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Direct Care Workers. All providers must be an RN, an LPN, or meet personal assistant standards. All staff must receive training for service quality. The Department may require a CNA for personal assistance when a participant's medical condition warrants. ()

02. Training for Participants with DD. When services provided in a participant's home require more than physical assistance, providers must complete a Department-approved DD training course or have experience providing direct services to people with DD unless the provider qualifies as a QIDP. The Department may temporarily approve staff meeting all qualifications except for the required training course or experience, when the Department verifies: ()

a. No other qualified providers are available; ()

b. The direct care worker is enrolled in the next available training course with a graduation date no more than six (6) months from the request for temporary provider status; and ()

c. A supervising QIDP provides monthly oversight visits until the direct care worker graduates from the training program. ()

03. Children's PCS Delivered in a Provider's Home. Providers must be licensed or certified as a child foster care or PCS FACH. ()

04. Health Screen. Direct Care staff must complete a health questionnaire, kept in their personnel files. If they have a medical issue, a statement from a medical provider must verify they are able to perform all required duties. Misrepresentation of information is cause for termination of employment and disqualifies an employee from providing Medicaid services. ()

05. Personal Assistance Agency (PAA) and Fiscal Intermediaries. ()

a. Recruit, hire, fire, train, supervise, schedule, process payroll, and ensure all direct care staff are qualified to provide quality services; ()

b. Maintain liability insurance coverage; ()

c. Ensure staffing of an RN or, when applicable, a QIDP supervisor to develop and complete service plans and provide supervision of service delivery; ()

d. Assign qualified staff to participants honoring their choices; and ()

e. Conduct annual participant satisfaction or quality control reviews available to the Department and the public. ()

555. PCS: REIMBURSEMENT.

01. Calculated Fee. Fees include a basic rate for PCS and mileage. No separate charges are paid for provider transportation to and from a participant's home or non-medical transportation, unless authorized by the Department under another billable service. ()

02. Rate Methodology. Rates are calculated using an annual survey of all Idaho NFs and ICFs/IID to establish the WAHR for Idaho NF employees in comparable positions. ()

03. PAA Rates. The Department establishes PAA rates for PCS based on the WAHR multiplied by a supplemental component composed of costs reported for travel, administration, training, and all payroll taxes and fringe benefits collected during the most recent State Fiscal Year. ()

04. CFH and RALF Rates. PCS rates for residents are paid based on their assessed care level as follows: ()

a. Level I, any diagnosis EXCEPT Serious and Persistent Mental Illness (SPMI), DD, Alzheimer's Disease and Related Dementias (ADRD) = one and twenty-five hundredths (1.25) hrs/day. ()

b. Level II, any diagnosis EXCEPT SPMI, DD, ADRD = one and five tenths (1.5) hrs/day. ()

c. Level III, any diagnosis = two and twenty-five hundredths (2.25) hrs/day. ()

d. Level IV, ONLY SPMI, DD, ADRD who scores at level one (1) or two (2) = one and seventy-nine hundredths (1.79) hrs/day. ()

05. Supervisor RN and QIDP Rates. The Department authorizes oversight activities paid per visit to conduct participant evaluations and for Service Plan development and may authorize additional evaluations or emergency visits as needed. ()

556. PCS: QUALITY IMPROVEMENT (QI).

Providers must respond within forty-five (45) days of receiving results of a Department review. Providers must implement a QI plan for identified problems and provide results upon request. ()

557. – 559. (RESERVED)

SUB PART: ENHANCED DD SERVICES
(Sections 560-579)

560. DD SERVICES: REQUIREMENTS.

DD services, including Family-Directed Community Supports (FDCS), are covered when provided with the right care, in the right place, at the right price, and with the right outcomes to enhance health and safety, and promote participants' rights, self-determination, and independence. Services require an assessment of the need for services, development of a service plan with the budget assigned by the Department, PA of services, and a quality improvement program. ()

01. Right Care. Standard of care for the diagnosis, functional needs, and abilities to achieve the desired outcome. ()

02. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. ()

03. Right Price. The most integrated and least expensive services that are sufficient to address the participant's needs as identified in the assessment. ()

04. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. ()

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: ()

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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. ()

562. (RESERVED)

563. DD DETERMINATION STANDARDS: TEST INSTRUMENTS.

01. Assessments. A Department-approved tool for conducting cognitive and functional assessments is used to determine eligibility. An appropriate professional must verify tests over one (1) year old reflect the individual's status. ()

02. Children's Test Instruments. Evaluations must be performed by qualified personnel with experience and expertise with children using age-appropriate evaluation tools and practices, considering the child's language and motor skills. ()

564. DD SERVICES: QUALITY IMPROVEMENT.

01. Quality Improvement (QI). Audit findings may lead to quality improvement (QI) activities, which consist of the Department and providers working to resolve identified issues and enhance services provided including consultation, technical assistance, and recommendations. If deficiencies are not resolved, corrective action occurs. ()

02. Corrective Action. A formal process to address significant or unresolved deficiencies identified during the review process that includes issuance of a corrective action plan, reporting to Medicaid Program Integrity Unit, or termination of a provider agreement. ()

03. Abuse, Fraud, or Substandard Care. Suspected abuse, fraud, or substandard care is referred to the Department and other applicable agencies. ()

565. (RESERVED)

566. DD SERVICES: ADMINISTRATIVE APPEALS.

Applicants and participants may file an administrative appeal if they disagree with Department decisions affecting individual rights, including eligibility determinations, assessment results, budget assignments, exception reviews, and authorization of services or service plans. ()

567. (RESERVED)

568. ADULT DD SERVICES: DEFINITIONS.

01. Clinical Review. Process of professional review to validate the need for continued services. ()

02. Exception Review. Clinical review of a plan falling outside established standards due to a health or safety risk. ()

03. Health. The prevention of deterioration of one's physical or mental health condition, cognitive functioning, or an increase in maladaptive behavior, and is related to the effects of one's disability. ()

04. Health Risks. Must be established through written documentation and current treatment recommendations from a licensed practitioner of the healing arts under these rules, or other professional licensed by the State of Idaho whose recommendation is within the scope of their license. Such documentation must establish: ()

a. The current physical or mental condition, or cognitive functioning that will likely deteriorate, or the current maladaptive behavior(s) that will likely increase; and ()

b. The specific supports or services being requested, including type and frequency if applicable, that will address the identified need. ()

c. To comply with the documentation requirement, the Department may require the participant to obtain additional consultation or assessment, available to the participant and covered by Medicaid, from a

professional licensed by the State of Idaho acting within the scope of their license. If the Department requires additional consultation or assessment, the Department will specify the nature of the consultation or assessment and the necessary documentation. ()

05. Safety. Prevention of criminal activity, destruction of property, or injury or harm to self or others. ()

06. Safety Risks. Must be documented by the following: ()

a. Current incident reports; ()

b. Police reports; ()

c. Assessments from a licensed practitioner of the healing arts under these rules or a professional licensed in Idaho and whose assessment is within the scope of their license; or ()

d. Status reports and implementation plans that reflect the type and frequency of intervention(s) in place to prevent the risk and the participant's progress under such intervention(s). ()

e. Such documentation must establish: ()

i. An imminent or likely safety risk; and ()

ii. The specific supports or services that are being requested, including the type and frequency if applicable, that are likely to prevent that risk. ()

569. ADULT DD SERVICES: ELIGIBILITY DETERMINATION.

Participants aged eighteen (18) or older are eligible for adult DD services when they meet DD determination standards. ()

570. (RESERVED)

571. ADULT DD SERVICES: COVERAGE AND LIMITATIONS.

PA is required for service coordination, DD waiver and DD state plan services. Services must be delivered under a service plan by providers selected by the participant. ()

572. ADULT DD SERVICES: PROCEDURAL REQUIREMENTS.

Providers must immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, and injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other required entity. ()

573. ADULT DD SERVICES: SERVICE PLAN REQUIREMENTS.

The service plan identifies the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and providers. The service plan must include activities to promote progress, maintain functional skills, or delay or prevent regression. Unless the participant has a guardian, who retains full decision-making authority, the participant must make decisions regarding the type and amount of services. The Department, with the participant, ensures the service plan is based on the individualized participant budget. The plan developer must distribute a copy of the service plan, in whole or part, to any other provider identified by the participant during the person-centered planning process. ()

01. Assessment. The assessment with a Department-approved tool for DD service eligibility is required for all participants prior to plan development and includes: ()

a. History and Physical. A medical provider's assessment and referral for nursing services and developmental therapy if anticipated to be part of the service plan. A history and physical is required within the year prior to the initiation of service and updated annually, by the medical provider. ()

b. Medical, Social, and Developmental Assessment (MSDA). An assessment reviewed annually to assure it accurately reflects the participant's status. The current assessment must be evaluated prior to the initiation of adult DD services. Providers obtain and use this assessment documentation for adult program or service plan development. ()

c. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. ()

d. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. ()

02. Paid Plan Developer Qualifications. Providers of direct services to the participant, or the assessor, cannot be chosen to be a paid plan developer. Plan development requires an individual be employed as a service coordinator. ()

03. Plan Development. The plan development process must meet the HCBS person-centered planning requirements. The participant may facilitate their own person-centered planning meeting or designate a paid or non-paid plan developer. ()

04. No Duplication of Services. The plan developer ensures that there is no duplication of services. ()

05. Plan Monitoring. The planning team, including a plan monitor, must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring includes contacting providers to identify barriers to service delivery, discussing participant satisfaction with the quality and quantity of their services, and review of provider status reviews. ()

06. Provider Status Reviews. Providers required to develop a PIP must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual review is due fifteen (15) days after the end of the sixth month. The annual review is due thirty (30) days after plan's end. Semi-annual and annual reviews include status of supports and services to identify progress, maintenance, or delay or prevention of regression. ()

07. Informed Choice. Prior to plan development, the plan developer must document they provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. Planning team members must each indicate whether they believe the service plan meets the needs of the participant and represents the participant's choice. If there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the service plan or amendment may be referred to the Department to negotiate a resolution. ()

08. Provider Implementation Plan (PIP). Providers must develop a PIP that complies with HCBS setting requirements and identifies specific measurable objectives that relate to goals finalized and agreed to in the participant's authorized service plan. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the service plan. ()

a. Exceptions. A PIP is not required for providers of: ()

i. Specialized medical equipment; ()

ii. Home-delivered meals; ()

iii. Environmental accessibility adaptations; ()

iv. Non-Medical Transportation; ()

- v. Personal Emergency Response System; ()
- vi. Respite care; ()
- vii. Chore services; ()
- viii. Community crisis support services; ()
- ix. Adult DD service coordination; and ()
- x. Adult Day Health. ()

b. Time To Complete. PIPs must be completed within fourteen (14) days of receipt of the authorized service plan, or the service start date, whichever is later. If the authorized service plan is received after the service start date, providers must support billing by documenting service delivery as agreed to by the participant and consistent with these rules. PIP revisions must be based on changes to the needs of the participant. ()

c. PIP changes must be included in the participant's record, stating the reason for the change, documentation of coordination with other providers, the date a change was made, and the name and title of the person making the change. ()

09. Addendum to the Service Plan. ()

a. A service plan may be adjusted during the year with an addendum, subject to Department PA. These adjustments must be based on a change to a cost, addition or increase of a service, change of provider, addition of a restrictive intervention, or addition or increase of alone time. Additional assessments or information may be clinically necessary. ()

b. The Department distributes a copy of the authorized addendum to providers responsible for the implementation of the plan. ()

c. Upon receipt of the addendum, the provider must sign the addendum indicating they have reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision with their title and the date signed and maintained in the participant's record. Provider signatures are completed each time an addendum is authorized. ()

10. Annual Service Reauthorization. A new service plan must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current service plan for personal assistance unless delayed because of participant unavailability due to extenuating circumstances. If the service plan is not submitted within the period, authorization for provider payments may be terminated. Prior to submission, the plan developer must notify the providers who appear on the service plan of the annual review date, obtain a copy of the most recent provider status review, and convene the person-centered planning team to develop a new service plan. ()

11. Notifications. The Department notifies participants of its decision on their service plan. Notification includes an individualized explanation and how to appeal. ()

574. ADULT DD SERVICES: PROVIDER REIMBURSEMENT. Providers are reimbursed on a fee-for-service basis based on a participant budget. ()

01. Individualized Budget. The Department sets an individualized budget annually for each participant and notifies them of their set budget amount as part of the eligibility process. Notification includes information on appealing the set budget amount. Individualized budgets may be re-evaluated at the participant's request when there are documented changes in their condition with medical necessity for services not reflected in the current inventory of needs. ()

02. Exception Review. Service plans or addenda requesting services exceeding the assigned budget

authorized by the assessor are reviewed and authorized by the Department. Requests are authorized when one (1) of the following is met: ()

a. Services requested on the plan or addendum are needed to assure participant health and safety or to mitigate a documented health or safety risk. ()

b. Supported employment is needed for the participant to obtain or maintain employment. ()

03. Supported Living Levels of Support. Reimbursement for supported living is based on the participant's assessed level of support need. All service plans for supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and they are less dependent on supports, they must transition to less intense supports. ()

a. High support is for participants who require twenty-four (24) hour per day supports and supervision. A blend of one-to-one and group staffing is allowed. Developmental therapy, ADH, and NMT are included in this daily rate. ()

b. Intense support is for participants who require one-on-one, twenty-four (24) hour per day supports and supervision. Requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Developmental therapy, ADH, and NMT are included in this daily rate. To qualify for intense support, participants must be evaluated to meet one of the following criteria: ()

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. ()

ii. History of predatory sexual offenses and at high risk to re-offend. ()

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. ()

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring, without which would require placement in a NF, hospital, or ICF/IID with twenty-four- (24) hour on-site nursing. ()

c. Hourly support is for individuals whose needs can be met with less than twenty-four (24) hour per day support. The combination of hourly supported living, developmental therapy, supported employment, and ADH cannot exceed the maximum set daily amount established by the Department, except when: ()

i. A participant is eligible for high support; ()

ii. Supported employment is included in the service plan, causing the combination to exceed the daily limit; ()

iii. Documentation confirming the Person-Centered Planning team explored other options including lower-cost services and supports; and ()

iv. A participant's health and safety needs can be met using hourly services. ()

575. – 579. (RESERVED)

SUB-PART: CHILDREN'S DD HCBS STATE PLAN OPTION
(Sections 580-589)

580. CHILDREN'S DD HCBS STATE PLAN OPTION: DEFINITIONS.
Definitions also apply to Family-Directed Community Supports (FDCS). ()

01. Community. Natural, integrated environments outside of the participant's home, outside of DDA center-based settings, or at school outside of school hours. ()

02. Family-Centered Planning Process. A participant-focused planning process facilitated by the plan developer and directed by the participant or the participant's decision-making authority to help them make informed choices about the services and supports included on the service plan. ()

03. Family-Centered Planning Team. A group who discusses the participant's strengths, needs, and preferences, including their safety and the safety of those around them to develop the participant's service plan. This group includes the participant, the participant's decision-making authority, plan developer, and people chosen by the participant and the family. ()

581. CHILDREN'S DD HCBS STATE PLAN OPTION: ELIGIBILITY DETERMINATION.
Eligibility also applies to Family-Directed Community Supports (FDCS). ()

01. Eligibility Determination. A participant is eligible for the children's DD HCBS state plan option from birth through age seventeen (17), when they have a DD and a demonstrated need for these services. ()

02. Individualized Budget Methodology. The following categories are used to determine individualized budgets for children with DD. ()

a. Level I. Children meeting DD criteria. ()

b. Level II. Children who qualify based on functional limitations when their composite full-scale standard score of less than fifty (50) or have an overall standard score up to fifty-three (53) when combined with a maladaptive behavior score of greater than one (1) to less than two (2) standard deviations from the mean. ()

c. Level III. Children who qualify based on functional limitations with a composite full-scale standard score less than fifty (50) with an autism spectrum disorder diagnosis. ()

d. Level IV. Children who qualify based on maladaptive behaviors when their maladaptive behavior score is two (2) standard deviations or greater from the mean. ()

03. Annual Re-Evaluation. Budgets are re-evaluated annually or at the request of the participant, the Department when there are documented changes that may support placement in a different budget category. ()

04. Lapse in Service. For participants re-applying for services, the assessor evaluates whether assessments are current and accurately describe the status of the participant. ()

582. CHILDREN'S DD HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
All children's DD HCBS are identified on a service plan developed by the family-centered planning team and must be prior authorized. ()

01. Respite. Supervision on an intermittent or short-term basis for unpaid caregiver relief or in response to a family emergency or crisis, provided by a DDA or an independent provider. Payment does not include room and board. Respite may be provided in a participant's home, the private home of the independent provider, a DDA, or in the community. The following limitations apply: ()

a. Not be provided to enable an unpaid caregiver to work. ()

b. Only participants living with an unpaid caregiver are eligible. ()

c. Cannot exceed fourteen (14) consecutive days. ()

d. Must not be provided at the same time as other Medicaid services except family education for an unpaid caregiver. ()

e. Providers must not use restraints on participants, other than physical restraints in the case of an emergency, to prevent injury to the participant or others and as documented in the participant's record. ()

f. When group respite is community or center-based, there must be at least one (1) qualified staff member providing direct services to every two (2) to six (6) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the participant ratio must be adjusted accordingly. ()

g. Independent providers cannot provide center-based respite and may only provide group respite when the provider is a relative and the service is delivered in the participant's or provider's home. ()

02. Community-Based Supports. Facilitates a participant's independence and integration into the community by providing an opportunity to explore their interests, practice skills learned in other therapeutic environments and learn through interactions in typical community activities. Community-based supports must: ()

a. Not supplant services provided in school or therapy, or the role of a primary caregiver; ()

b. Ensure involvement in age-appropriate activities in integrated settings; and ()

c. Have at least one (1) qualified staff providing direct services for up to six (6) participants when provided as group community-based supports. As the number and severity of the participants with functional impairments or behavioral needs increase, the staff participant ratio must be adjusted accordingly. ()

03. Family Education. Professional assistance to caregivers to help them meet the participant's needs by providing an orientation to DDs and to educate them on generalized strategies for behavioral modification and intervention techniques specific to a participant's diagnosis and the needs identified on the service plan. Training may be provided in a group setting not exceeding five (5) families. Providers must survey the parent or legal guardian's satisfaction of services immediately following a family education session. ()

04. Family-Directed Community Supports (FDCS). Families of eligible participants may choose to direct an individualized budget rather than receive traditional children's DD HCBS state plan option services when the participant lives at home with their parent or legal guardian. FDCS must be delivered on a one-to-one basis as identified on the service plan and requires PA and quality assurance. ()

05. Limitations for State Plan and Family-Directed Community Supports (FDCS). ()

a. Services are limited by the participant's individualized budget amount. ()

b. Services offered under the Medicaid Basic Plan cannot be authorized. ()

c. Duplication of services cannot be provided: ()

i. Goals are not separate and unique to each item or service provided; or ()

ii. When more than one (1) service is provided at the same time, unless otherwise authorized. ()

583. CHILDREN'S DD HCBS STATE PLAN OPTION: SERVICE PLAN.

In collaboration with the participant, the Department ensures the participant develops one (1) service plan within their individualized participant budget. Paid plan development is provided by the Department. ()

01. History and Physical. Prior to the development of the service plan, the plan developer must obtain a current history and physical completed by a medical provider annually, or earlier as determined by the medical provider. Also, required for Family-Directed Community Supports (FDCS). ()

02. Service Plan Development. The service plan is developed with the participant, their decision-

making authority, facilitated by the Department. If the participant is unable to attend the family-centered planning meeting, the service plan must contain documentation justifying their absence. Also, required for Family-Directed Community Supports (FDCS). ()

03. Requirements for Collaboration. Providers must coordinate with the family-centered planning team as specified on the service plan. Also, required for Family-Directed Community Supports (FDCS). ()

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months. The plan monitor meets face-to-face with the participant and their decision-making authority at least annually. ()

05. Provider Status Reviews. Community-Based Support providers must submit six (6) month and annual provider status reviews to the plan monitor. Six-month status reviews must be submitted thirty (30) days prior to the six-month date listed on the plan. Annual provider status reviews must be submitted forty-five (45) days prior to expiration of the existing plan. ()

06. Addendums. A service plan may be adjusted with an addendum when based on changes in participant needs, requested and signed by a decision-making authority, and PA by the Department. The Department distributes the addendum to providers involved in implementation. Providers must review an addendum upon receipt, and sign and return it to the Department, maintaining a copy in the participant's record. ()

07. Annual Reauthorization for State Plan and Family-Directed Community Supports (FDCS). ()

584. CHILDREN'S DD HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

01. Supervision. All providers must be supervised by an intervention specialist or professional. Observation and review of direct services must be performed monthly, or more often as needed, ensuring staff demonstrate the necessary skills to correctly provide services. ()

02. Quality Assurance. Providers must demonstrate high quality of services through internal quality assurance reviews. ()

03. Documentation. Providers must maintain records for each participant served. Failure to maintain documentation results in recoupment of payments for undocumented services. Documentation must include: ()

- a. Visit date and time in and out; ()
- b. Services provided; ()
- c. Session summary; ()
- d. Service location; and ()
- e. Signature of the provider and date signed. ()

585. CHILDREN'S DD HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES.

01. Respite. Provided by a DDA or an independent provider meeting these minimum qualifications: ()

- a. Be at least sixteen (16) years old when employed by a DDA or eighteen (18) years old when an independent provider; ()
- b. Receive instructions in the participant's needs; ()

- c. Demonstrate ability to provide services according to a service plan; and ()
 - d. Obtain and maintain CPR and first aid certification prior to delivering services. ()
 - 02. **Community-Based Support.** Provided by a DDA or an independent provider meeting these minimum qualifications: ()
 - a. Be at least eighteen (18) years old; ()
 - b. Receive instructions in the participant's needs; ()
 - c. Demonstrate ability to provide services according to a service plan; ()
 - d. Be supervised or have six (6) months supervised experience working with children with DD. ()
 - e. Complete coursework approved by the Department demonstrating competencies related to providing community-based supports; and ()
 - f. Obtain and maintain CPR and first aid certification prior to delivering services alone. ()
 - 03. **Family Education.** Provided by a DDA or an independent intervention specialist or professional. ()

586. CHILDREN'S DD HCBS STATE PLAN OPTION: REIMBURSEMENT.
Providers are reimbursed on a fee-for-service basis for services identified on a participant's service plan. ()

587. – 589. (RESERVED)

ADULT DD HCBS STATE PLAN OPTION
(Sections 590-609)

590. ADULT DD HCBS STATE PLAN OPTION.
DD state plan services are provided through an HCBS State Plan option for adults with DD, and who do not meet ICF/IID level of care. ()

591. ADULT DD HCBS STATE PLAN OPTION: ELIGIBILITY.
Individuals must be eighteen (18) years or older, live in the community, and meet DD determination standards. ()

592. COMMUNITY CRISIS SUPPORTS.
Interventions for participants determined eligible for Adult DD HCBS State Plan services who risk losing housing, employment, income, or at risk of incarceration, physical harm, or family altercations. ()

593. COMMUNITY CRISIS SUPPORTS: COVERAGE AND LIMITATIONS.
Services are authorized after an intervention when a documented need for immediate intervention exists, no other supports were available, and services were appropriate to rectify the crisis. Services are limited to a maximum of twenty (20) hours during any consecutive 5-day period. ()

01. Emergency Room (ER). Services may be provided in an ER during the evaluation process if the goal is to prevent hospitalization and return to the community. ()

02. Before Plan Development. Services may be provided before completion of the service plan when the service plan includes identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. ()

03. Crisis Resolution Plan. After services are provided, the provider must complete and submit a

crisis resolution plan to the Department for approval within five (5) business days. ()

594. – 599. (RESERVED)

600. DEVELOPMENTAL THERAPY.

The Department pays for services to eligible participants with recommendations from a medical provider and provided by licensed DDAs. ()

601. (RESERVED)

602. DEVELOPMENTAL THERAPY: COVERAGE AND LIMITATIONS.

01. Coverage. Developmental therapy is delivered in a DDA center-based program, the community, or the participant's home, and includes individual developmental therapy and group developmental therapy. Services must: ()

a. Be directed toward rehabilitation or habilitation of physical or DDs in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. ()

b. Include age-appropriate instruction in ADLs not gained by a participant during normal developmental stages or not likely to develop without training or therapy. ()

c. Not include tutorial activities or assistance with educational tasks associated with educational needs resulting from a disability. ()

d. Both individual and group therapy must be available based on participant needs, interests, or choices. ()

e. Include a minimum of one (1) qualified staff member providing direct services for every twelve (12) participants when center based. ()

f. Occur in integrated, inclusive settings with no more than three (3) participants per qualified staff at each community-based session. Additional staff must be added when necessary to meet the needs of each individual served. ()

02. Limitations. Developmental therapy may not exceed these limitations: ()

a. No more than twenty-two (22) hours per week. ()

b. No more than forty (40) hours per week in combination with ADH and supported employment. ()

c. Only one (1) type of Medicaid-reimbursable therapy during a single period. ()

d. Cannot be reimbursed when providing transportation to and from the agency. ()

603. DEVELOPMENTAL THERAPY: INDIVIDUAL SERVICE PLAN (ISP) REQUIREMENTS.

01. Intake. Prior to service delivery, DDAs must obtain a participant's current MSDA and authorized ISP. ()

02. Plan Changes. Changes to the ISP or PIP must be documented in the participant's record, and include the reason for the change, the date of change, and the name and title of the professional making the change. ()

604. DEVELOPMENTAL THERAPY: INDIVIDUAL PROGRAM PLAN (IPP) PROCEDURAL REQUIREMENTS.

01. Intake. Participants receiving HCBS A&D waiver services or PCS only requesting Developmental Therapy, may access services using an IPP, which does not require a DD plan developer. Services delivered through an IPP must be authorized by the Department and be based on the A&D waiver Service Plan. Prior to service delivery, a DDA must complete an IPP that meets the standards below. ()

02. IPP Development. IPPs must: ()

a. Be developed after completion of all required assessments; ()

b. Be signed prior to delivery of services by a medical provider, the participant, and their legal guardian if applicable; ()

c. Be developed at least annually, or more often, when necessary, to review or update the IPP to reflect any changes in the participant's needs or status; and ()

d. Promote self-sufficiency, participant choice in program objectives and activities, encourage participant's participation and inclusion in the community, and contain age-appropriate objectives. ()

03. IPP Changes. Changes to an IPP require notification and written authorization by the participant and their legal guardian if one (1) exists. Changes in type, amount, or duration of services must be recommended by a medical provider in writing. If the signatures of the participant or their legal guardian cannot be obtained, the DDA must document in the participant's record why signatures were not obtained. PIP changes must include the following documentation in the participant's record: ()

a. Reason for a change; ()

b. Coordination with other service providers, when applicable; ()

c. Date of change; and ()

d. Signature, date, credentials, and title of the professional making the change. ()

605. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.

DDAs must obtain all assessments required for DD services eligibility, billing no more than four (4) hours for the combination of all assessment, evaluation, or diagnostic services provided in a calendar year. The following assessment and diagnostic services are reimbursable: ()

01. Comprehensive Developmental Assessment. Assessments must: ()

a. Be conducted by a Developmental Specialist and determine necessity of a service, guide treatment, and identify the participant's current strengths, needs, and interests. ()

b. Be signed and dated by the professional completing the assessment, including their appropriate professional credentials or qualifications. ()

c. Reflect the current status of the participant with assessments completed or updated at least every two (2) years. ()

d. Reflect a person's developmental status in the following areas: ()

i. Self-care; ()

ii. Receptive and expressive language; ()

- iii. Learning; ()
- iv. Gross and fine motor development; ()
- v. Self-direction; ()
- vi. Capacity for independent living; and ()
- vii. Economic self-sufficiency. ()
- 02. Specific Skill Assessments.** These assessments must: ()
 - a. Further assess an area of limitation or deficit identified on a comprehensive developmental assessment. ()
 - b. Relate to a goal on an IPP or ISP. ()
 - c. Be conducted by qualified professionals to determine a participant's skill level within an area. ()
 - d. Be used to determine baselines and develop a PIP. ()
- 03. Documentation Requirements.** DDAs must maintain records for each participant served. Each record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following documentation is required: ()
 - a. Daily entry of all activities conducted toward meeting their objectives. ()
 - b. Sufficient progress data accurately assessing a participant's progress toward each objective; ()
 - c. Review of data, and, when applicable, changes in the daily activities or implementation procedures by the qualified professional, including their dated initials. ()
 - d. Documentation for six (6) month and annual reviews by the Developmental Specialist including a written description of the participant's progress toward their achievement of therapeutic goals, and reasons they continue to need services. ()
 - e. Authorized service plan. ()
- 04. PIP Requirements.** The DDA must develop a PIP for each DDA objective included on the participant's IPP or ISP. All PIPs must relate to a goal or objective on the participant's IPP or ISP. PIPs must be developed within fourteen (14) days of service start date or receipt of an authorized IPP or ISP and be revised whenever participant needs change. If the PIP is not completed within fourteen (14) days, the participant's records must contain participant-based documentation justifying the delay. The provider addresses goals and objectives as agreed to by the participant until the annual PIP is completed and documents service delivery related to their interim goals and objectives. The PIP must include: ()
 - a. Participant's name. ()
 - b. A baseline statement addressing the participant's skill level and abilities related to specific skills to be learned. ()
 - c. Measurable, behaviorally stated objectives corresponding to the goals or objectives authorized in the service plan. ()
 - d. Written instructions for staff that include curriculum, interventions, task analyses, activity

schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward stated objectives. ()

e. Identification of the environments where services are provided. ()

f. Target date for completion. ()

05. Informed Objectives. Results from a psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided by the DDA accommodate the participant's mental health needs and none of the therapeutic methods are contra-indicated or delivered in a manner that presents risks to the participant's mental health status. ()

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. ()

607. STAFFING REQUIREMENTS.

01. Paraprofessional Standards. When a paraprofessional provides developmental therapy, the DDA must ensure adequate supervision by a Developmental Specialist during service hours. The following standards apply: ()

a. DDAs must ensure paraprofessionals do not conduct assessments, establish service plan, or develop a PIP. These activities are conducted by a Developmental Specialist. ()

b. On a weekly basis or more often, if necessary, DDAs must ensure a Developmental Specialist is available for all paraprofessionals under their supervision to give instructions, review progress, and provide training on the programs and procedures. ()

c. DDAs must ensure that a Developmental Specialist, on a monthly basis or more often, if necessary, observes and reviews the work performed by paraprofessionals under their supervision, to ensure they are trained on the programs and demonstrate necessary skills to correctly implement them. ()

02. Agency Staffing Requirements. Each DDA must employ an administrator accountable for all service elements and who is employed on a continuous, regularly scheduled basis. The administrator is accountable for the overall operations of the DDA including ensuring compliance with rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. ()

a. When the administrator is not a Developmental Specialist, the DDA must employ a Developmental Specialist on a continuous, regularly scheduled basis who is responsible for the service elements of the agency; and ()

b. The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing DD services to individuals with DD. ()

608. – 609. (RESERVED)

ADULT DD HCBS WAIVER SERVICES
(Sections 610-629)

610. ADULT DD WAIVER SERVICES.

The Department provides waiver services to eligible participants, preventing unnecessary institutionalization, allowing the greatest degree of independence possible, enhancing the quality of life, encouraging individual choice, and achieving and maintaining community integration. ()

611. ADULT DD WAIVER SERVICES: PARTICIPANT ELIGIBILITY.

The Department determines waiver eligibility. The participant must meet the following: ()

01. Age. Be eighteen (18) years or older. ()

02. Eligibility. The Department must determine whether: ()

a. The participant would qualify for ICF/IID level of care if the DD waiver services were not available; ()

b. The participant can reside safely and effectively in a non-institutional setting; and ()

c. The average annual cost of a participant's waiver and other medical services do not exceed the average annual cost to Medicaid for ICF/IID care and other medical costs. ()

03. DD Waiver Eligibility. Participants eligible for DD waiver services may instead choose admission to an ICF/IID. ()

04. Redetermination. ()

a. Financial and medical redetermination are conducted annually or sooner at the request of the participant, self-reliance, a provider agency, or medical provider. ()

b. The redetermination process will assess the participant's continued need and eligibility for waiver services and discharge from the waiver services program. ()

05. Notifications. The Department notifies participants of the eligibility decision after an assessment. Notification includes an individualized explanation of the decision and how they may appeal. ()

06. Adult DD Waiver Limits. The number of Medicaid participants to receive waiver services under the Adult DD waiver is limited to the projected number of users in a CMS-approved waiver. Individuals applying for this waiver after the maximum is reached are placed on a waiting list to have their applications processed after September 30th for the new DD waiver year. ()

612. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. An integrated array of individually tailored services and supports designed to assist participants reside successfully in their own homes, with their families, or in CFHs. The number of residents in a setting will be limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department. Residential Habilitation consists of the following: ()

a. Habilitation services to help an individual acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity, and include training in at least one (1) of the following areas: ()

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; ()

ii. Money management; ()

iii. Daily living skills; ()

iv. Socialization not including participation in non-therapeutic activities that are diversional or recreational in nature; ()

v. Mobility; and ()

vi. Behavior shaping and management. ()

b. Personal Assistance Services that assist an individual in ADL, household tasks, and other routine activities as the participant or their primary caregivers are unable to accomplish on their own. ()

c. Skills training to teach participants and supports to perform activities with greater independence and to reinforce habilitation training. ()

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

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

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

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

06. Environmental Accessibility Adaptations. Minor housing adaptations necessary for a participant

to function with greater independence in their home, or without which, would require institutionalization or pose a risk to health or safety, including: ()

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

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

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

07. Specialized Medical Equipment and Supplies. ()

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

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

c. Items reimbursed under this waiver exclude items that are not of direct medical or remedial benefit to the participant. ()

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

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

10. Skilled Nursing. Intermittent or continuous oversight, training, or skilled care within the scope of the Nurse Practice Act provided by an RN or LPN under the supervision of an RN. Services cannot cost more than a Home Health visit. ()

11. Behavior Consultation/Crisis Management. Direct consultation and clinical evaluation of participants currently experiencing, or expected to experience, a psychological, behavioral, or emotional crisis. Services may provide training and staff development related to the participant's needs and provide emergency back-up involving the direct support for a participant in crisis. ()

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

13. Self-Directed Community Supports. DD waiver participants may choose to self-direct an individualized budget rather than receive traditional waiver services. ()

14. Transition Services. Goods and services enabling a participant residing in a NF, hospital, IMD, or ICF/IID to transition to a community-based setting immediately following discharge from a facility after a minimum of forty-five (45) days. ()

a. Services may include: ()

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

15. Limitations. Participants cannot receive DD waiver services in non-HCBS settings or RALFs. ()

613. ADULT DD WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Service Authorization. All waiver services must be identified on a service plan and authorized by the Department. The service plan must be reviewed by a plan monitor or service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. ()

02. Documentation Required. ()

- a.** Written documentation of each visit made or service provided to a participant including: ()
 - i. Service date; ()
 - ii. Service(s) provided; ()
 - iii. Statement of the participant's response to services, including any changes in the participant's condition; ()
 - iv. Length of visit, including time in and out. Unless a participant is determined by a Service Coordinator to be unable to do so, the delivery is verified by the participant by signing the service record; and ()
 - v. A copy of the above information is maintained in the participant's home unless the Department authorizes elsewhere. Failure to maintain documentation results in recoupment for undocumented services. ()
- b.** Service plans must specify the services required by a participant. A copy maintained in the participant's home must be available to all service providers and the Department. ()
- c.** PIP and provider status reviews, if required. ()

03. Provider Notification. Providers must notify the plan monitor and document on the service record when any significant changes in participant's condition are noted during service delivery. ()

614. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Residential Habilitation – Supported Living. Employment by a licensed residential habilitation

- agency. Direct care staff must: ()
- a. Be at least eighteen (18) years old; ()
 - b. Be free from communicable disease; ()
 - c. Demonstrate the ability to administer the plan of service; ()
 - d. Have a valid driver's license and vehicle insurance, if transporting participants; ()
 - e. Receive training by a QIDP who has demonstrated experience in writing skill training programs. Training programs must include an orientation program completed before providing services, and additional ongoing training during employment. ()
- 02. Residential Habilitation – CFH.** Individuals providing direct services in their own home must be a CFH, receive program coordination provided through the Department, and: ()
- a. Be free from communicable disease; ()
 - b. Have a valid driver's license and vehicle insurance, if transporting participants; and ()
 - c. Have certification or licensure to perform tasks requiring certification or licensure. ()
 - d. Prior to delivering services to a participant, complete an orientation training provided by the Department and additional training requirements for CFH providers within six (6) months of certification date. ()
- 03. Chore Services.** Be skilled in the service to be provided and demonstrate the ability to follow a service plan. ()
- 04. Respite Care.** Receive instructions in the participant's needs, demonstrate the ability to follow a service plan, and be free of communicable disease. ()
- 05. Supported Employment.** Provided by an agency accredited by CARF or meet State requirements to be an agency. ()
- 06. Non-Medical Transportation.** Possess a valid driver's license and vehicle insurance. ()
- 07. Specialized Medical Equipment.** Enrollment as a supplier and ensure all items meet applicable standards of manufacture, design, and installation. Preference is given to the most cost-effective option to meet the participant's needs. ()
- 08. PERS.** Demonstration that the devices installed in a participant's home meet FCC standards. ()
- 09. Home-Delivered Meals.** Provided by a public agency or business ensuring: ()
- a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the USDA; ()
 - b. Meals are delivered in a sanitary manner, and at the correct temperature for the specific type of food; and ()
 - c. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions. ()
- 10. Behavior Consultation or Crisis Management.** ()

a. Work under the direct supervision of a psychologist or PhD in Special Education with training and experience treating severe behavior problems and applied behavior analysis; and ()

i. Have a Master's degree in a behavioral science or a closely related field; ()

ii. Be a licensed pharmacist; or ()

iii. Be a QIDP. ()

b. Emergency back-up providers must meet the qualifications of a residential habilitation agency. ()

11. Adult Day Health. ()

a. Services provided in a facility must meet the building and health standards under IDAPA 16.03.21; ()

b. Provide care and supervision appropriate to the participant's needs as identified on the plan. ()

c. Free from communicable disease. ()

12. Transition Services. Transition managers. ()

615. ADULT DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.

Reimbursement rates for services include both services and mileage. Mileage for provider transportation to and from the service delivery location is not reimbursable. ()

616. – 619. (RESERVED)

620. HEALTH HOME.

The Intellectual Disability/Mental Illness (ID/MI) Health Home is a multi-disciplinary team providing an array of person-centered healthcare services to eligible participants transitioning across systems of care and living in the least restrictive environment possible. ()

621. HEALTH HOME: ELIGIBILITY REQUIREMENTS.

Participants diagnosed with an intellectual disability and a Serious Mental Illness, or Autism, and their acuity exceeds the existing level of traditional community services. Eligibility will be determined by the Department. Participants must receive one (1) Health Home service per month to maintain eligibility. ()

622. HEALTH HOME: COVERAGE AND LIMITATIONS.

Health home services include comprehensive case management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. ()

623. HEALTH HOME: PROCEDURAL REQUIREMENTS.

Idaho Medicaid and ID/MI Health Home will coordinate Health Home services through an intra-agency agreement published on the Department's website. ()

624. HEALTH HOME: PROVIDER QUALIFICATIONS AND DUTIES.

The ID/MI Health Home will be administered by the Department. Providers of Health Home services must be employed by, or contracted with, the ID/MI Health Home and meet all staff qualifications as specified in the intra-agency agreement. ()

625. HEALTH HOME: PROVIDER REIMBURSEMENT.

Reimbursement for Health Home services will be paid per the fee schedule. ()

626. – 629. (RESERVED)

SUB AREA: SERVICE COORDINATION
(Sections 630-639)

630. SERVICE COORDINATION: DEFINITIONS.

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

02. Crisis. An unanticipated event, circumstance, or life situation placing a participant at risk of hospitalization, loss of housing, loss of employment or major source of income, incarceration, or physical harm to self or others, including family altercation or psychiatric relapse. ()

631. SERVICE COORDINATION: PARTICIPANT ELIGIBILITY.

01. Adults. A DD diagnosis and a need for assistance to access service and supports necessary to maintain their independence. ()

02. Children. All information necessary to make an eligibility determination must be received by the Department twenty (20) business days prior to the anticipated service coordination start date. The Department determines eligibility based on information provided by the service coordination agency or the family prior to the initiation of initial and ongoing plan development and services. Participants must meet the following requirements: ()

a. Age of thirty-seven (37) months through the month of their 21st birthday. ()

b. A diagnosis with special health care needs requiring medical and multidisciplinary rehabilitation services identified by a medical provider to prevent or minimize disability. ()

c. Reimbursement for services is not available for participants whose needs can be met by other paid or unpaid sources. The child must require service coordination for one (1) or more of the following: ()

i. A condition resulting in functioning below normal age level in one (1) or more life areas; ()

ii. At risk of placement in a more restrictive environment or returning a child from an out of home placement due to their condition; ()

iii. Danger to the health or safety of the child exists or a parent is unable to meet the child's needs; ()

iv. Further complications may occur due to the condition without service coordination; or ()

v. Requires multiple service providers and treatments. ()

632. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.

The Department covers service coordination for individuals who are unable, or have limited ability to gain access, coordinate, or maintain services on their own or through other means. These rules are not applicable to case management services provided under the managed care contracts. ()

01. Plan Assessment and Reassessment. Activities required when determining participant needs during plan development and reassessment that include completing documentation related to a participant's history, identifying a participant's needs, and gathering information to form a complete assessment of the participant. ()

02. Plan Development. Development and revision of a service coordination plan including

information collected through the assessment and specifying goals and actions needed by the participant. Plans must be updated annually or as needed to meet participant needs. ()

03. Monitoring and Follow-Up. Contacts necessary to ensure a plan is implemented and adequately addresses a participant's needs and conducted as frequently as necessary. Activities must include one (1) or more face-to-face contacts with a participant at least every ninety (90) days and may occur via synchronous virtual care to determine: ()

a. Services are provided according to the plan; ()

b. Services in the plan are adequate; and ()

c. Whether there are changes in the needs or status of a participant, requiring adjustments to the plan or service arrangements with providers. ()

04. Crisis Assistance. Coordination used to help a participant access community resources to resolve a crisis that does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. ()

a. Crisis Assistance hours are unavailable until all available hours of service coordination have already been provided in the month. ()

b. Authorization for crisis assistance is requested retroactively due to a crisis when a participant's service coordination benefits are exhausted, and no other support is available. A service coordinator must complete a crisis resolution plan and submit a request for crisis services to the Department within five (5) business days of the last day of providing the service. ()

05. Contacts. Service coordination may include contacts with non-eligible individuals only when a contact directly relates to identifying the needs and supports to help a participant access services. ()

06. Exclusions. Service coordination does not include activities that are integral components of another covered service, integral to administration of foster care programs, or integral to administration of another program a participant is eligible for, except case management required by IDEA. ()

07. Limitations. ()

a. Providers may only deliver service coordination and direct services to the same Medicaid participant when they receive children's services coordination. ()

b. Service coordination cannot exceed four point five (4.5) hours per month, unless accessing unused hours in an individual's current plan from previous months. ()

c. Reimbursement for annual assessment and plan development cannot exceed twelve (12) hours per year. ()

d. Participants receiving hospice services or who live in hospitals, NFs, or ICF/IIDs are not eligible for service coordination. ()

e. Participants are only eligible for one (1) type of service coordination. Participants who qualify for more than one (1) type, must choose one (1) that best meets their needs. ()

f. Group services are not reimbursable. ()

g. Missed appointments, attempted contacts, travel to provide services, leaving messages, scheduling appointments with a Medicaid-enrolled service coordinator, transporting participants, or documenting services are not reimbursable. ()

633. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

- 01. Prior Authorization.** ()
- 02. Plan Development.** A plan must be developed and implemented within sixty (60) days after a participant chooses a service coordinator. ()
- 03. Documentation.** Agencies must maintain documentation describing services provided, reviewing the continued need for service coordination, and progression towards each service coordination goal. ()
- 04. Freedom of Choice.** A participant must have freedom of choice when selecting providers. ()
- 05. Contact and Availability.** The plan must identify the frequency, mode of contact, and provider to be contacted, which must meet the participant's needs. The plan must also identify the frequency of face-to-face contact with each participant. ()
- a.** When a provider must conduct a face-to-face contact with a child without a parent or legal guardian present, the provider must notify them prior to the contact and document the notification in the participant's file. ()
- b.** Providers do not have to be available twenty-four (24) hours a day but must include an individualized objective on the plan describing who to contact in an emergency and how the provider will obtain needed services during an emergency. ()
- 06. Conflict of Interest.** Providers must be alert to, and avoid, conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. They must inform the participant, parent, or legal guardian when a real or potential conflict of interest arises, take reasonable steps to resolve the issue with the participant's interests first, and protect their interests to the greatest extent possible. ()
- a.** Providers developing a participant's plan cannot: ()
- i.** Be related by blood or marriage to the participant or to any paid caregiver of the participant; ()
- ii.** Be financially responsible for the participant; ()
- iii.** Make financial or health-related decisions on behalf of the participant; ()
- iv.** Hold financial interests in any entity paid to provide care for the participant; or ()
- v.** Provide any State Plan HCBS or waiver services to the participant or have an interest in or be employed by providers for the participant. ()
- b.** Agencies must guard against conflicts of interest and ensure its employees and contractors meet the conflict-of-interest standards. They must include documentation in each participant's file, signed by the participant, parent and or legal guardian, that defines "conflict of interest," and includes a provider-signed statement verifying that conflict of interest was reviewed and explained. ()

634. SERVICE COORDINATION: PROVIDER QUALIFICATIONS AND DUTIES.

- 01. Provider Agreement.** Providers must be employees or contractors of an agency. ()
- 02. Supervision.** Agencies must provide supervision to all providers by clearly documenting each supervisor's ability to address concerns about the services provided under their supervision. ()
- 03. Supervisor Requirements.** ()

a. Master's Degree in a human services field, and twelve (12) months supervised work experience with the population served; or ()

b. Bachelor's degree in a human services field or RN, and twenty-four (24) months supervised work experience with the population served. ()

04. Service Coordinator Requirements. ()

a. Bachelor's degree in a human services field or RN and twelve (12) months supervised work experience with the population served. ()

b. Individuals meeting education or licensing requirements but without the required supervised work experience must be supervised by a qualified service coordinator while gaining the required work experience. ()

05. Paraprofessional Requirements. Under the supervision of a qualified service coordinator, a paraprofessional can assist in the implementation of the plan. Paraprofessionals cannot conduct assessments, evaluations, person-centered planning meetings, 90-day face-to-face contacts, 180-day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as a service coordinator on the plan and cannot supervise service coordinators or other paraprofessionals. They must: ()

a. Be eighteen (18) years or older with a high school diploma or equivalency and twelve (12) months supervised work experience with the population served; and ()

b. Be able to read and write at a level necessary to process all paperwork and forms required for service delivery. ()

06. Health, Safety, and Fraud Reporting. Providers must report any concerns about fraud, health, and safety to the appropriate governing agency and the Department. ()

07. Case Loads. The total caseload of a provider must assure quality service delivery and participant satisfaction. ()

635. SERVICE COORDINATION: PLAN DEVELOPMENT – ASSESSMENT.

Service coordinators must complete the service coordination assessment as part of person-centered planning to identify a participant's need for assistance accessing and coordinating care and services. The participant's needs and supports must be documented in the assessment. The participant, parent, legal guardian, and other providers identified by the participant must be included in the process. The assessment is used to determine a participant's prioritized needs and services which must be documented in the plan. For children, assessments must identify the family's needs to ensure their child's needs are met. ()

636. SERVICE COORDINATION PLAN.

The plan must specify goals and actions addressing the service coordination needs of a participant identified in the assessment. The service coordination plan for adults with DD must comply with and be incorporated into their DD service plan. ()

637. SERVICE COORDINATION: REIMBURSEMENT.

01. Duplication. Payments must not duplicate payment made under similar programs. ()

02. Payment. Reimbursable services include plan development, face-to-face contact, two-way communication between a service coordinator and a participant, their other providers, family members, primary caregivers, legal guardian or other interested persons, and referrals or related activities to obtain needed services identified in the plan. ()

03. Medical Institutionalization. Service coordination reimbursement for the day a participant is admitted to or discharged from a medical facility is allowed when the service occurs prior to admission or after

discharge. ()

a. Services that help a participant reintegrate into the community are only reimbursable when provided during the last fourteen (14) days for inpatient stays under one hundred eighty (180) days or the last sixty (60) days for inpatient stays one hundred eighty (180) days or more. Claims cannot be filed for services provided until after participant discharge. ()

b. Services must not duplicate activities provided during a facility's admission or discharge process. ()

04. Delivered Prior to Assessment. On-going service coordination is not allowable prior to completion of a plan. ()

638. – 639. (RESERVED)

YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION
(Sections 640-649)

640. YES HCBS STATE PLAN OPTION: INDEPENDENT ASSESSMENT.

Comprehensive clinical diagnostic assessment using a Department-approved tool identifying a child's needs, strengths, and degree of functional impairment, administered by a Department-designated independent assessor. The assessment process includes: ()

01. Evaluation. The child's current behavioral health, living situation, relationships, and family functioning; ()

02. Contact. Necessary contacts with significant individuals; and ()

03. History. Review of a child's clinical, educational, social, and behavioral health, and juvenile justice history. ()

641. YES HCBS STATE PLAN OPTION: REDETERMINATION.

Eligibility is redetermined by an independent assessment every twelve (12) months. The Department may extend eligibility to allow for unavoidable delays. ()

642. YES HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.

01. Respite Care. Supervision of a participant on an intermittent or short-term basis allowing relief to a primary unpaid caregiver of a YES participant in response to a family emergency or crisis, or on a regular basis to provide caregiver relief. Payment and administration of respite care is done through managed care contracts. ()

02. Person-Centered Planning. A person-centered planning team directs the development of the service plan. ()

643. – 649. (RESERVED)

SUB AREA: HOSPICE
(Sections 650-659)

650. HOSPICE.

Medicaid pays for hospice services based on Medicare program coverage. ()

651. HOSPICE: DEFINITIONS.

01. Benefit Period. Period beginning the first day of the month a participant elects hospice and ending the last day of the 11th successive calendar month. ()

02. Election Period. One (1) of eight (8) periods within a benefit period that a participant may elect to receive hospice care. Each period consists of any calendar month, or portion thereof, chosen within a benefit period. ()

03. Hospice Agency. Public agency or private organization that primarily provides care to terminally ill participants and meets the Medicare conditions for certification. ()

652. HOSPICE: ELIGIBILITY.
Hospice eligibility requires: ()

01. Certification of Participant Terminal Illness. ()

02. Medically Necessary. For the palliation and management of a terminal illness and related conditions. ()

03. Participant Election of Services. ()

04. Informed Consent. Participants must receive education on the reason for and nature of hospice care prior to service delivery. ()

653. HOSPICE: COVERAGE AND LIMITATIONS.
Core services and requirements include those in 42 CFR 418.64, 42 CFR 418.76, 42 CFR 418.106, 42 CFR 418.108, 42 CFR 418.110, 42 CFR 418.112, and physical, occupational, and speech-language therapy services provided for symptom control or enabling a participant to maintain ADLs and basic functional skills. ()

654. HOSPICE: PROCEDURAL REQUIREMENTS.

01. Physician Certification. The hospice must obtain certification of a participant's terminal illness as follows: ()

a. For any period of coverage, the provider must obtain, no later than two (2) calendar days after initiating care, written certification statements signed by the hospice medical director or a physician member of a hospice interdisciplinary group and the participant's attending physician, when applicable. Certification must verify a participant's life expectancy is six (6) months or less. If a participant's medical prognosis or the appropriateness of hospice care is questionable, the Department can obtain another physician's opinion to verify a participant's medical status. ()

b. Maintain monthly certification statements for review. ()

c. Notify Medicaid when a participant's designated attending physician is not a hospice employee. ()

02. Election Procedures. A participant or their representative must request hospice care by submitting an election statement to a hospice of their choice. ()

a. Elections for hospice care are effective through any subsequent election periods without a break in care when a participant does not change providers or revoke an election. ()

b. A participant who elects less than eight (8) monthly election periods within a benefit period may request additional election periods available when they meet the following conditions: ()

i. Available hospice days did not exceed two hundred ten (210) days in a benefit period due to loss of financial eligibility; ()

ii. Hospices were not changed excessively; and ()

- iii. More than eight (8) election periods were not revoked. ()
- c. A participant cannot request an effective date earlier than the date of their election. ()
- d. A participant twenty-one (21) years of age or older must waive all rights to Medicaid payments for the duration of an election period of hospice care for services related to their terminal condition except when provided under hospice services. ()

03. Hospice Election. Participant statements must identify their choice of hospice provider and an effective date, acknowledge their informed choice of hospice care and waiver of any non-excepted Medicaid services during hospice benefit periods, and be signed and dated by the participant or their representative. ()

04. Election Revocation. Participants or their representatives may revoke an election at any time by filing a signed statement with the hospice that includes their request to revoke an election of hospice care and an effective date. Medicaid coverage is reinstated upon revocation. ()

05. Hospice Change. Participants may request a change of provider during any eligible election period, but no more than six (6) times during a benefit period. Participants must submit a signed and dated statement to the current provider and the new provider during the monthly election period, that includes the current hospice care provider, new hospice provider requested, and effective date. Changes in provider ownership do not apply. ()

06. Plan of Care. Must be established and reviewed at least monthly and include all covered services and supplies. The basic interdisciplinary group member assessing a patient's needs must confer with at least one (1) other member before writing an initial plan of care. At least one (1) person involved in developing an initial plan must be an RN or physician. Plans must be established on the same day as an assessment to be covered as part of hospice care. The other two (2) basic interdisciplinary group members must review an initial care plan and provide input to the process of establishing the plan within two (2) calendar days following the assessment. ()

655. HOSPICE: PROVIDER QUALIFICATIONS AND DUTIES.
Providers must submit a list of physicians, including volunteer physicians, employed by the hospice in their provider application and update any changes to this list. ()

656. HOSPICE: REIMBURSEMENT.
Except for payment of physician services, Medicaid pays for hospice care under one (1) of five (5) predetermined daily rates depending on type and intensity of services. There are no retroactive rate adjustments other than application of a "cap" on overall payments, a service intensity add-on, and limitations on inpatient care payments. Payment levels include: ()

01. Routine Home Care. Payment includes one (1) of two (2) routine home care rates for each day of residence, under hospice care, and not receiving continuous home care. The rate paid disregarding the volume or intensity of routine services provided any given day. The two-rate payment methodology results in a higher payment for days one (1) through sixty (60) of hospice care and a reduced rate for all subsequent days. If a participant leaves hospice care and later resumes hospice care, regardless of provider, a minimum 60-day gap in hospice services is required for payment of the higher base routine home care rate. If a minimum 60-day gap in hospice services is not met, providers are paid the lower base rate. ()

02. Continuous Home Care. Continuous home care is provided only during crisis periods when a patient requires continuous nursing care to achieve palliation and manage acute medical symptoms. Care must be provided by either an RN or LPN for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a 24-hour day beginning and ending at midnight and does not need to be continuous and uninterrupted. Less skilled care needed on a continuous basis to enable a person to remain at home is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate is paid to the hospice up to twenty-four (24) hours per day. ()

03. Inpatient Respite Care. Payment is the inpatient respite care rate for each day a participant resides in an approved inpatient facility receiving respite care. Payment for a maximum of five (5) days includes the admission date but not the discharge date in any monthly election period. Payment for the sixth and any subsequent

days is made at an appropriate rate: routine, continuous, or general inpatient rate. ()

04. General Inpatient Care. Payments are made for general inpatient care provided. No other fixed payment rates are applicable for a day a participant receives hospice general inpatient care except qualifying physician services. ()

a. An appropriate home care rate is paid for discharge dates unless a patient dies in an inpatient unit. Date of a patient death is considered the discharge date and paid at the inpatient rate. ()

b. Medicaid hospice rates are the same as Medicare hospice rates, adjusted to disregard cost offsets for Medicare coinsurance amounts. No cost sharing is imposed for participants receiving hospice services. ()

c. Medicaid hospice benefits continue after a participant's Medicare hospice benefit expires. The hospice must continue providing care until a patient dies or revokes a hospice care election. ()

05. Service Intensity Add-On. Add-on payments are made for visits by an RN or social worker during the last seven (7) days of life in addition to the routine home care rate, calculated by multiplying the continuous home care rate per fifteen (15) minutes by the number of units for combined daily visits. Payments do not exceed sixteen (16) units per day, are adjusted for geographic wage differences, and do not include a social worker's phone time. ()

657. HOSPICE: INPATIENT PAYMENT LIMITATIONS.

If the Department determines an inpatient rate should not be paid, any days a provider receives payment at a home care rate is not counted as inpatient days. Limitations include: ()

01. Maximum Allowable Inpatient Days. Calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%). If the total amount exceeds the maximum number of allowable inpatient days, a payment limitation is determined by: ()

a. Calculating the ratio of the maximum allowable inpatient days to the number of actual inpatient care days and multiplying the ratio by the total payment for inpatient care made. ()

b. Multiplying excess inpatient care days by the routine home care rate. ()

c. Adding the two (2) calculated amounts and comparing the sum to interim inpatient hospice care payments made during the "cap period." ()

02. Limitation Cap. When any interim payments for inpatient care exceed the limitation, a provider must return the amount over the limitation. ()

658. HOSPICE: PHYSICIAN PAYMENTS.

Basic hospice care rates represent full payment to the provider for all costs of covered services, including administrative and general activities performed by physicians employed by or working under a hospice. ()

01. Hospice Employed Physicians. Payment for direct patient services is made under the Medicaid rate methodology for physician services and related payments are counted in the overall hospice cap. Providers may only bill for physician's direct patient care services. Laboratory and X-ray services are included in the hospice daily rate. ()

02. Volunteer Physicians. Volunteer services are excluded from Medicaid payment except when the hospice is reimbursed on behalf of a volunteer physician for specific direct patient care services not rendered on a volunteer basis, and a hospice must reimburse a physician for services rendered. A physician must not provide voluntary services based on a patient's ability to pay. ()

03. Independent Physicians. These services are reimbursed outside of the hospice benefit. Laboratory or X-ray services are excluded and must be provided by the hospice. ()

659. HOSPICE: REIMBURSEMENT CAP.

Aggregate payments to each hospice are limited during a hospice cap period. Total payments made for services during this period are compared to the “cap amount” for each period. Providers must return any payments more than the cap. ()

01. Overall Cap. The cap is compared to reimbursement after computing the inpatient limitation and subtracting from the total reimbursement amount. ()

02. Total Payment. All payments for services rendered during a cap year, regardless of when payment is made. ()

03. Calculation of Cap. “Cap amount” is calculated by multiplying the number of participants of hospice care during the period by an amount adjusted for each cap year reflecting the percentage change in the medical care expenditure category of the Consumer Price Index for all urban consumers as published by the U.S. Bureau of Labor and Statistics. ()

04. Number of Participants. Providers must report the number of Medicaid participants receiving hospice care during each period to the Department within thirty (30) days after the end of a cap period. For participants transferred to a non-certified hospice where no payment is made to the non-certified hospice, the certified provider may count a complete participant benefit period in their cap amount. ()

05. Certified Mid-Month. A weighted average cap amount based on the number of days falling within each cap period is used. ()

06. Adjustment to Overall Cap. Amounts in each hospice’s cap period are adjusted to reflect changes in the cap periods and designated hospices during a participant’s election period. The proportion of each hospice’s service days to the total number of hospice days rendered to a participant during an election period is multiplied by the cap amount to determine an adjusted cap amount. ()

a. Each hospice’s adjusted cap amount is computed as follows: ()

i. The share of the “cap amount” allowed by each hospice is based on the proportion of total covered days provided by each hospice in a “cap period.” ()

ii. The maximum number of allowable inpatient days for each certified hospice is multiplied by the “cap amount” specified for the “cap period” in which the participant first elected hospice. ()

b. The participant must file an initial election during the period beginning September 28 of the previous year through September 27 of the current cap year for it to count as an election during the current cap year. ()

07. Additional Amount for NF Residents. Additional per diem amounts are paid for “room and board” of hospice residents in a NF who receive routine or continuous care services. Room and board include all assistance with ADLs, socializing activities, medication administration, maintaining cleanliness of resident rooms, and supervising and assisting use of DME and prescribed therapies. Additional payments are not subject to payment caps. Room and board rates are ninety-five percent (95%) of per diem interim rates assigned to a facility for the dates a participant resides in a NF. ()

660. HOSPICE: PATIENT LIABILITY.

The Department reduces payments for the hospice benefit, including supplementary room and board amounts, by an amount determined during the participant eligibility process. ()

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 FDCCS 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. FDCCS 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 be 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)

**DUAL ELIGIBLES
(Sections 960 - 979)**

SUB AREA: MEDICARE SAVINGS PROGRAM
(Sections 960-969)

960. MEDICARE SAVINGS PROGRAM.

01. AABD Effective Date. Effective date for participants approved for Medicaid and AABD cash is the first month of AABD cash eligibility. ()

02. SSI Effective Date. Effective date for participants approved for Medicaid who also receive SSI, but not AABD cash, is the first month of Medicaid eligibility. ()

03. Neither AABD nor SSI Effective Date. Effective date for participants approved for Medicaid who do not receive AABD cash or SSI is the third month of Medicaid eligibility. ()

961. – 969. (RESERVED)

SUB AREA: MEDICARE/MEDICAID COORDINATED PLAN (MMCP)
(Sections 970-979)

970. MANAGED CARE FOR DUALS.

Medicaid benefit plan, referred to collectively as the Medicare/Medicaid Coordinated Plan (MMCP), for dual-eligible participants to enroll in a managed care organization (MCO) offering Idaho Medicaid Plus (IMPlus) or MMCP health plans. ()

971. MANAGED CARE FOR DUALS: DEFINITIONS.

01. Dual Eligible. Participants with enhanced plan benefits, except those from Breast and Cervical Cancer eligibility, who are also enrolled in both Medicare Parts A and B. ()

02. Evidence of Coverage. Contract between an MCO and the participant detailing covered services. ()

03. Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP). Health plan option that fully integrates Medicare and Medicaid benefits under a single MAO. ()

04. Idaho Medicaid Plus (IMPlus). MMCP health plan option where most Medicaid covered services are provided by one MCO. ()

05. Medicare Advantage Organizations (MAOs). MCO approved by CMS to offer Medicare Advantage Plans. ()

06. Medicare Advantage Plan. Private health plans contracted with CMS to provide Medicare Parts A, B, and D benefits. ()

07. Medicare/Medicaid Coordinated Plan (MMCP). MMCP health plan option integrating Medicare and Medicaid covered services under a FIDE-SNP provided by one MCO. ()

08. Passive Enrollment. Process where the Department assigns a participant to an IMPlus plan unless the participant actively enrolls in MMCP or opts out of IMPlus. ()

972. MANAGED CARE FOR DUALS: PROGRAM AUTHORITY.

MCOs seeking to offer IMPlus and/or MMCP health plans operate under Department contract and appropriate CMS approval. ()

01. IMPlus. CMS approval of MCO under 1915(b) authority. ()

- 02. MMCP.** CMS approval of MAO to operate a Medicare Advantage Plan. ()

973. MANAGED CARE FOR DUALS: ELIGIBILITY AND ENROLLMENT.

Only dual eligible participants over age twenty-one (21) may enroll in IMPlus or MMCP plans. Enrollment requirements vary by county. ()

- 01. Exclusions.** Individuals receiving Adult DD 1915(c) waiver benefits are excluded from IMPlus enrollment. ()

- 02. Exemptions.** Tribal members and pregnant women are exempt from mandatory enrollment requirements but may voluntarily enroll in MMCP plan options when available in their county of residence and retain the right to disenroll at any time. ()

- 03. Voluntary Counties.** Participants residing in a county with at least one (1) participating MCO may voluntarily enroll in MMCP under an available IMPlus or MMCP plan and may terminate from a plan at any time. Coverage continues until the end of the month of termination. Once disenrolled, MMIS reenrolls participants under fee-for-service Medicaid. ()

- 04. Mandatory Counties.** Participants without an exclusion and residing in a county with two (2) or more active MCOs must enroll in either an IMPlus or MMCP plan. The Department assigns participants who fail to choose a plan into an IMPlus MCO. ()

- 05. Passive Counties.** The Department enrolls participants without an exclusion and residing in a county with only one (1) participating MCO into the MCO's IMPlus plan unless they enroll in the MCO's MMCP plan or opt out by contacting the Department. These participants may opt out of IMPlus at any time. ()

974. MANAGED CARE FOR DUALS: COVERAGE AND LIMITATIONS.

- 01. Coverage.** All MMCP plan options include Medicaid-only Basic and Enhanced Plan services provided by Medicaid providers that are not MAOs. Medicaid may cover additional services not included in the MCO's Evidence of Coverage. MAOs providing MMCP plans may limit or expand MAO-covered services, including Medicare Parts A, B, and D benefits or supplemental services unavailable on Medicaid or Medicare, as detailed in the contract and Evidence of Coverage. ()

- 02. Limitations.** Services not included in the Evidence of Coverage are carved out and provided under fee-for-service Medicaid or other contracted entities. ()

975. – 979. (RESERVED)

INVESTIGATIONS, AUDITS, AND ENFORCEMENT
(Sections 980 - 999)

SUB AREA: LIENS AND ESTATE RECOVERY
(Sections 980-989)

980. (RESERVED)

981. LIENS AND ESTATE RECOVERY: DEFINITIONS.

- 01. Adequate Consideration.** An act, object, services, or other benefit which has a tangible and/or intrinsic value that is equivalent to or greater than the fair market value of the transferred asset. ()

- 02. Authorized Representative.** The person appointed by the court as the personal representative in a probate proceeding or the person identified by the participant to receive notice and make decisions on estate matters. ()

- 03. Discharge From a Medical Institution.** A medical decision made by a competent provider that the

participant no longer needs nursing home care because the participant's condition has improved, or the discharge is not medically contraindicated. ()

04. Home. The dwelling in which the participant has an ownership interest, and which the participant occupied as their primary dwelling prior to, or subsequent to, their admission to a medical institution. ()

05. Institutionalized Participant. An inpatient in a NF, ICF/IID, or other medical institution, who is a Medicaid participant subject to post-eligibility treatment of income in IDAPA 16.03.05. ()

06. Lawfully Residing. Residing in a manner not contrary to or forbidden by law, and with the participant's knowledge and consent. ()

07. Permanently Institutionalized. An institutionalized participant of any age who the Department has determined cannot reasonably be expected to be discharged from the institution and return home. Discharge refers to a medical decision made by a competent provider that the participant is physically able to leave the institution and return to live at home. ()

08. Personal Property. Any property that is not real property, including cash, jewelry, household goods, tools, life insurance policies, boats, and wheeled vehicles. ()

09. Real Property. Any land, including buildings or immovable objects attached permanently to the land. ()

10. Residing in the Home on a Continuous Basis. Occupying and continuing to occupy the home as the primary residence. ()

11. Termination of a Lien. The release or dissolution of a lien from property. ()

12. Undue Hardship. Conditions that justify waiver or deferral of all or a part of the Department's claim against an estate. ()

13. Undue Hardship Waiver. A decision made by the Department to relinquish, limit, or defer its claim to any or all estate assets of a deceased participant based on good cause. ()

982. LIENS AND ESTATE RECOVERY: NOTIFICATION TO DEPARTMENT.

All notification regarding liens, estate claims, and requests for notice must be directed to the Department of Health and Welfare, Estate Recovery Unit, 450 W. State Street, 6th Floor, Boise, Idaho 83702. ()

983. LIENS AND ESTATE RECOVERY: LIEN DURING LIFETIME OF PARTICIPANT.

01. Lien Imposed During Lifetime of Participant. During the lifetime of the permanently institutionalized participant, except as noted, the Department may impose a lien against the real property of the participant for medical assistance correctly paid on their behalf. The lien must be filed within ninety (90) days of the Department's final determination, after notice and opportunity for a hearing, that the participant is permanently institutionalized. The lien is effective from the beginning of the most recent continuous period of the participant's institutionalization. Any lien imposed will dissolve upon the participant's discharge from the medical institution and return home. ()

02. Determination of Permanent Institutionalization. The Department must determine that the participant is permanently institutionalized prior to the lien being imposed. An expectation or plan that the participant will return home with the support of HCBS does not, in and of itself, justify a decision that they are reasonably expected to be discharged to return home. The following factors must be considered when making the determination of permanent institutionalization: ()

a. The participant must meet the criteria for NF or ICF/IID level of care and services; ()

b. The medical records must be reviewed to determine if the participant's condition is expected to

improve to the extent that they will not require NF or ICF/IID level of care; and ()

c. Where the prognosis indicated in the medical records is uncertain or inconclusive, the Department may request additional medical information or may delay the determination until the next utilization control review or annual Inspection of Care review, as appropriate. ()

03. Notice of Determination of Permanent Institutionalization and Hearing Rights. The Department must notify the participant or their authorized representative, in writing, of its intention to decide that the participant is permanently institutionalized, and that they have the right to a fair hearing. This notice must inform the participant of the following information, at a minimum: ()

a. The Department's decision that they cannot reasonably be expected to be discharged from the medical institution to return home is based upon a review of the medical records and plan of care, but that this does not preclude them from returning home with services necessary to support NF or ICF/IID level of care; and ()

b. They or their authorized representative may request a fair hearing prior to the Department's final determination that they are permanently institutionalized. The notice must include information that a pre-hearing conference may be scheduled prior to a fair hearing. The notice must include the time limits and instructions for requesting a fair hearing. ()

c. If they or their authorized representative does not request a fair hearing within the time limits specified, their real property, including their home, may be subject to a lien, except as noted. ()

04. Recovery Upon Sale of Property Subject to Lien Imposed During Lifetime of Participant. Should the property upon which a lien is imposed be sold, the Department will seek recovery of all medical assistance paid on behalf of the participant, except as noted. Recovery of the medical assistance paid on behalf of the participant from the proceeds from the sale of the property does not preclude the Department from recovering additional medical assistance paid from the participant's estate. ()

05. Filing of Lien During Lifetime of Participant. When appropriate, the Department will file, in the office of the Recorder of the county in which the real property of the participant is located, a verified statement, in writing, setting forth the following: ()

a. The name and last known address of the participant; and ()

b. The name and address of the official or agent of the Department filing the lien; and ()

c. A brief description of the medical assistance received by the participant; and ()

d. The amount paid by the Department, as of a given date, and, if applicable, a statement that the amount of the lien will increase as long as medical assistance benefits are paid on behalf of the participant. ()

06. Renewal of Lien Imposed During Lifetime of Participant. The lien, or any extension thereof, must be renewed every five (5) years by filing a new verified statement, or as required by Idaho law. ()

07. Termination of Lien Imposed During Lifetime of Participant. The lien will be released as provided by Idaho Code, upon satisfaction of the Department's claim. The lien will dissolve in the event of the participant's discharge from the medical institution and return home. Such dissolution of the lien does not discharge the underlying debt, and the estate remains subject to recovery under estate recovery provisions under this rule. ()

984. LIENS AND ESTATE RECOVERY: REQUIREMENTS FOR ESTATE RECOVERY.

01. Recovery From Estate of Spouse. Recovery from the estate of the spouse of a Medicaid participant may be made as permitted in Sections 56-218 and 56-218A, Idaho Code. ()

02. Lien Imposed Against Estate of Deceased Participant. Liens may be imposed against the estates

of deceased Medicaid participants and their spouses as permitted by Section 56-218, Idaho Code. ()

03. Notice of Estate Claim. The Department will notify the authorized representative of the amount of the estate claim after the death of the participant, or after the death of the surviving spouse. The notice must include instructions for applying for an undue hardship waiver. ()

04. Assets in Estate Subject to Claims. Assets in the estate from which the claim can be satisfied must include all real or personal property that the deceased participant owned or in which they had an ownership interest, including the following: ()

a. Payments to the participant under an installment contract will be included among the assets of the deceased participant. This includes an installment contract on any real or personal property to which the deceased participant had a property right. The value of a promissory note, loan or property agreement is its outstanding principal balance at the date of death of the participant. When a promissory note, loan, or property agreement is secured by a Deed of Trust, the Department may request evidence of a reasonable and just underlying debt. ()

b. The deceased participant's ownership interest in another person's estate, probated or not probated, is an asset of their estate when: ()

i. Documents show the deceased participant is an eligible devisee or donee of property of another deceased person; or ()

ii. The deceased participant received income from property of another person; or ()

iii. State intestacy laws award the deceased participant a share in the distribution of the property of another estate. ()

c. Any trust instrument that is designed to hold or to distribute funds or property, real or personal, in which the deceased participant had a beneficial interest is an asset of the estate. ()

d. Life insurance is considered an asset when it has reverted to the estate. ()

e. Burial insurance is considered an asset when a funeral home is the primary beneficiary or when there are unspent funds in the burial contract. Any funds remaining after payment to the funeral home will be considered assets of the estate. ()

f. Checking and savings accounts that hold and accumulate funds designated for the deceased participant are assets of the estate, including joint accounts that accumulate funds for the benefit of the participant. ()

g. In a conservatorship situation, if a court order under state law specifically requires funds be made available for the care and maintenance of a participant prior to their death, absent evidence to the contrary, such funds are an asset of the deceased participant's estate, even if a court has to approve release of the funds. ()

h. Shares of stocks, bonds, and mutual funds to the benefit of the deceased participant are assets of the estate. ()

05. Value of Estate Assets. The Department will use fair market value as the value of the estate assets. ()

985. LIENS AND ESTATE RECOVERY: LIMITATIONS AND EXCLUSIONS.

01. Limitations on Estate Claims. Limits on the Department's claim against the assets of a deceased participant or spouse are subject to Sections 56-218 and 56-218A, Idaho Code. A claim against the estate of a spouse of a participant is limited to the value of the assets of the estate that had been, at any time after October 1, 1993, community property, or the deceased participant's share of the separate property, and jointly owned property. ()

02. Expenses Deducted From Estate. The following expenses may be deducted from the available assets to determine the amount available to satisfy the Department's claim: ()

a. Funeral expenses reasonably necessary for burial or cremation services approved on a case-by-case basis at the discretion of the Department. ()

b. Administrative expenses of the estate may be deducted in accordance with Section 56-218, Idaho Code. ()

03. Interest on Claim. The Department's claim does not bear interest until the claim becomes recoverable. Interest on the claim accrues at the legal rate of interest. ()

04. Excluded Land. Restricted allotted land, owned by a deceased participant who was an enrolled member of a federally recognized American Indian tribe, or eligible for tribal membership, which cannot be sold or transferred without permission from the Indian tribe or an agency of the Federal Government, will not be subject to estate recovery. ()

05. Certain Life Estates. The value of a life estate owned by a Medicaid participant, or their spouse will not be subject to estate recovery if: ()

a. Neither the Medicaid participant or their spouse ever owned the remainder interest; or ()

b. The life estate was created prior to July 1, 1995. ()

06. Marriage Settlement Agreement or Other Such Agreement. A marriage settlement agreement or other such agreement that separates assets for a married couple does not eliminate the debt against the estate of the deceased participant or the spouse. Transfers under a marriage settlement agreement or other such agreement may be voided if not for adequate consideration. ()

07. Undue Hardship Exception. It is not considered undue hardship when family members anticipate or expect an inheritance or will be inconvenienced economically by the lack of an inheritance. ()

a. An applicant for an undue hardship waiver must be family with a beneficial interest in the estate and must apply for the waiver within ninety (90) days of the death of the participant or within thirty (30) days of receiving notice of the Department's claim, whichever is later. The filing of a claim by the Department in a probate proceeding constitutes notice to all heirs. ()

b. Undue hardship waivers will be considered in the following circumstances: ()

i. The estate subject to recovery is income-producing property that provides the sole source of support for heirs; or ()

ii. Payment of the Department's claim would cause heirs of the deceased participant to be eligible for public assistance; or ()

iii. The Department's claim is less than five hundred dollars (\$500) or the total assets of the entire estate are less than five hundred dollars (\$500), excluding trust accounts or other bank accounts. ()

c. Any claim may be waived or deferred by the Department, partially or fully, because of undue hardship. An undue hardship does not exist if action taken by the participant prior to their death, or by their legal representative, divested or diverted assets from the estate. The Department grants undue hardship waivers on a case-by-case basis upon review of all facts and circumstances, including any action taken to diminish assets available for estate recovery or to circumvent estate recovery. ()

08. Set Aside of Transfers. Transfers of real or personal property of the participant without adequate consideration are voidable and may be set aside by the district court whether the asset transfer resulted, or could have resulted, in a period of ineligibility. ()

986. LIENS AND ESTATE RECOVERY: REQUEST FOR NOTICE.

01. Notice - Hearing. The Department must notify the participant or their authorized representative, in writing, of its intention to record a request for notice, and that they have the right to a fair hearing. The notice must inform the participant of the following information: ()

a. The Department's determination that they are the record titleholder or purchaser under a land sale contract of real property subject to a request for notice; ()

b. They or their authorized representative may request a fair hearing prior to the Department's recording a request for notice. The notice must include the time limits and instructions for requesting a fair hearing; and ()

c. If they or their authorized representative do not request a fair hearing within the time limits specified, a request for notice applying to their real property, including their home, may be recorded. ()

02. Forms - Content. The notices must include the following information: ()

a. The name of the public assistance recipient and the spouse of such public assistance recipient, if any; ()

b. The Medicaid number for the public assistance recipient and spouse, if any; ()

c. The legal description of the real property affected or to be affected; ()

d. The mailing address at which the Department is to receive notice; ()

e. If the document is a Notice of Transfer or Encumbrance, the name and address of the transferee or lien holder; and ()

f. A fully executed acknowledgment as required for recording under Section 55-805, Idaho Code. ()

03. Webpages for Forms. These forms may be found at <http://healthandwelfare.idaho.gov>. ()

a. Notice of Transfer or Encumbrance. ()

b. Request for Notice. ()

c. Termination of Request for Notice. ()

987. – 989. (RESERVED)

SUB AREA: PARTICIPANT LOCK-IN
(Sections 990 - 999)

990. PARTICIPANT UTILIZATION CONTROL PROGRAM.

This Program is to promote improved and cost-efficient medical management of essential health care by monitoring participant activities and taking action to correct abuses. Participants demonstrating unreasonable patterns of utilization or exceeding reasonable levels of utilization will be reviewed for restriction. The Department may require a participant to designate a primary provider or a single pharmacy for exclusive provider services to protect the individual's health and safety, provide continuity of medical care, avoid duplication of services by providers, avoid inappropriate or unnecessary utilization of medical assistance. ()

991. LOCK-IN DEFINED.

Lock-in is the process of restricting the access of a participant to a specific provider or providers. ()

992. DEPARTMENT EVALUATION FOR LOCK-IN.

The Department will determine if services are being utilized at a frequency or amount that is not medically necessary. Evaluations can include review of medical records or computerized reports reflecting claims. ()

993. CRITERIA FOR LOCK-IN.

There are no specific criteria for lock-in as each case is unique. The Department may develop non-binding guidelines for purposes of uniformity. The following utilization patterns may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or over utilization of Medicaid services, and may result in the restriction of Medicaid reimbursement for a participant to a single provider or providers: ()

01. Unnecessary Use of Providers or Services, Including Excessive Provider Visits. ()

02. Demonstrated Abusive Patterns. Recommendation from a provider that the participant has demonstrated abusive patterns and would benefit from the lock-in program. ()

03. Use of Emergency Room. Frequent use of emergency room for non-emergent conditions. ()

04. Multiple Providers. ()

05. Controlled Substances. ()

06. Use of Multiple Prescribing Providers or Pharmacies. ()

07. Overlapping Prescription Drugs With the Same Therapeutic Classes. ()

08. Drug Abuse. ()

09. Drug-Seeking Behavior. As identified by a provider. ()

10. Other Abusive Utilization. As determined by the Department's medical or pharmacy consultant. ()

994. LOCK-IN PARTICIPANT NOTIFICATION.

A participant designated by the Department for the Participant Utilization Control Program will be notified in writing by the Department of the action and the participant's right of appeal by means of a fair hearing. ()

995. LOCK-IN PROCEDURES.

01. Participant Responsibilities. The participant will be given thirty-five (35) days to contact the Regional Program Manager and complete and sign the lock-in agreement form and select designated provider(s) in each area of misuse. ()

02. Appeal Stays Restriction. The Department will not implement the participant restriction if a valid appeal is noted. ()

03. Lock-In Duration. The Department will restrict participants to their designated providers for a period determined by the Department. Upon review at the end of that period, lock-in may be extended for an additional period determined by the Department. ()

04. Payment to Providers. Payment to providers other than the designated lock-in provider or pharmacy is limited to documented emergencies or referrals. ()

05. Regional Programs Manager. The Regional Programs Manager will: ()

a. Clearly describe the participant's appeal rights; ()

- b.** Specify the effective date and length of the restriction; ()
- c.** Have the participant choose a designated provider or providers; and ()
- d.** Mail the completed lock-in agreement to the Surveillance and Utilization Unit. Upon receipt of the lock-in agreement, the participant's Medicaid services will be immediately restricted to the designated providers. ()

996. PENALTIES FOR LOCK-IN NONCOMPLIANCE.

If a participant fails to respond to the notification of medical restrictions, fails to sign the lock-in agreement, or fails to select a primary provider within the specified period, the Medicaid benefits will be restricted to documented emergencies only. If a participant continues to abuse or over-utilize items or services after being identified for lock-in, the Department may terminate Medicaid benefits for a specified period as determined by the Department. ()

997. APPEAL OF LOCK-IN.

Department determinations to lock-in a participant may be appealed. ()

998. RECIPIENT EXPLANATION OF MEDICAID BENEFITS (REOMBS).

01. Participant Response. A participant is required to respond to the Department's explanation of medical benefits survey whenever they are aware of discrepancies. ()

02. Participant Unable to Respond. If the participant is unable, because of medical or physical limitations, to respond to the survey personally, then a responsible family member or friend can respond on their behalf. ()

999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE
16.04.14 – LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)
DOCKET NO. 16-0414-2501 (CHAPTER REPEAL)
NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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.

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. As such, the chapters of 16.03.08, 16.06.13, and 16.04.14 are consolidated into what is proposed to be entitled IDAPA 16.03.08. 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 July 2nd, 2025, Idaho Administrative Bulletin, [Vol. 25-7, page 66](#).

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.

DATED this 31st day of July, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 16th, 2025.

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:

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. As such, the chapters of 16.03.08, 16.06.13, and 16.04.14 are consolidated into what is proposed to be entitled IDAPA 16.03.08.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted for 16.03.08 which is being proposed to be consolidated with 16.04.14 and 16.06.13. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking for 16.03.08 was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 21 and 22](#).

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 Jared Larsen at DHWRules@dhw.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 July 23rd, 2025.

DATED this 28th day of May, 2025.

IDAPA 16.04.14 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.04.17 – RESIDENTIAL HABILITATION AGENCIES

DOCKET NO. 16-0417-2501 (ZBR CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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.

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 chapter is proposed to be repealed and consolidated into Docket No. 16-0321-2501. Consolidating these two chapters will assist the Department and providers with efficiency and consistency while reducing regulatory burden and ensure the health and safety of the vulnerable individuals these organizations serve. This chapter includes requirements for Adult Residential Care Facilities that provides residential services to adult individuals with developmental disabilities. 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, page 336](#).

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.

DATED this 31st day of July, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 18th, 2025.

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

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

This chapter is proposed to be repealed and consolidated into Docket No. 16-0321-2501. Consolidating these two chapters will assist the Department and providers with efficiency and consistency while reducing regulatory burden and ensure the health and safety of the vulnerable individuals these organizations serve. This chapter includes requirements for Adult Residential Care Facilities that provides residential services to adult individuals with developmental disabilities.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 27 and 28](#).

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 Jared Larsen at DHWRules@dhw.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 June 25th, 2025.

DATED this 2nd day of May, 2025.

IDAPA 16.04.17 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.05.01 – USE AND DISCLOSURE OF DEPARTMENT RECORDS

DOCKET NO. 16-0501-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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) 39-242, 56-221, 56-222, 56-1003, and 56-1004, Idaho Code.

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

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. 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 4th, 2025, Idaho Administrative Bulletin, [Vol. 25-6, pages 337 through 351](#).

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.

DATED this 8th day of July, 2025.

Jared Larsen
Chief, Legislative and Regulatory Affairs
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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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 39-242, 56-221, 56-222, 56-1003, and 56-1004, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx	
Monday, June 9, 2025 9:00 AM (MT)	
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m65eaa06a89c8aa696eed4edb88030ae2	
Join by meeting number Meeting number (access code): 2821 862 0443 Meeting password: gRwyUApY754 Meeting password when dialing from a phone or video system: 47998279	
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)	
Wednesday, June 18, 2025 11:00 AM (MT)	
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=mb80e43040b27d406537522a26cb40aa1	
Join by meeting number Meeting number (access code): 2823 759 0089 Meeting password: JutVPKwE949 Meeting password when dialing from a phone or video system: 58887593	
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)	

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:

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: Fees will not be increased as a result of this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year as a result of this rulemaking: There is not anticipated to be a negative fiscal impact exceeding \$10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 29 and 30](#).

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 Jared Larsen at DHWRules@dhw.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 June 25th, 2025.

DATED this 2nd day of May, 2025.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0501-2501

16.05.01 – USE AND DISCLOSURE OF DEPARTMENT RECORDS

000. LEGAL AUTHORITY.

Sections 39-242, 56-221, 56-222, 56- 1003, and 56-1004, Idaho Code.

(7-1-25)

001. SCOPE.

These rules govern the use and disclosure of information maintained by the Department, in compliance with applicable state and federal laws, and federal regulations.

(7-1-25)

002. -- ~~006~~10. (RESERVED)

~~007. DISTRICT COURT APPEALS, COMPLAINTS AND REQUESTS FOR RECONSIDERATION.~~

~~The confidentiality of health information is defined in part by the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC 1320d, 110 Statutes at Large 2033-4, and 45 CFR Sections 160 and 164.~~

~~(3-17-22)~~

~~**01. Appeals to District Court.** Anyone who is aggrieved by a denial of disclosure or amendment of a public record may file an appeal in the appropriate district court in compliance with the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code.~~

~~(3-17-22)~~

~~**02. Complaints to Privacy Officer.** Individuals who are dissatisfied with a Department decision regarding confidential information may file a written complaint with the Department's Privacy Officer. Complaints must be submitted to the Department's Privacy Officer at the mailing address for the Department's business office.~~

~~The Privacy Officer determines if a complaint is valid and makes a recommendation for its resolution to the Department within twenty-eight (28) days after the complaint is received.~~ (3-17-22)

~~a. Secretary of Health and Human Services (HHS). Complaints that involve the use and disclosure of health information may also be submitted to the Secretary of Health and Human Services at the following address: The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201.~~ (3-17-22)

~~b. Time for filing complaints. Complaints must be filed within one hundred eighty (180) days from the date of the alleged violation.~~ (3-17-22)

~~03. Request for Reconsideration to Access Health Information. The individual or legal representative may submit a written request for reconsideration to the Privacy Officer if access to health information is denied.~~ (3-17-22)

~~a. The request for reconsideration must be postmarked no later than twenty-eight (28) days after notice of the denial was mailed.~~ (3-17-22)

~~b. The reconsideration will be conducted by another licensed health care professional who did not participate in the original decision.~~ (3-17-22)

~~c. The Department will notify the individual of the outcome of the review within twenty-eight (28) days after the request is received.~~ (3-17-22)

~~008.—009. (RESERVED)~~

010. DEFINITIONS.

~~01. Authorization. A time-limited written consent for the disclosure of confidential information to a specific individual or entity outside the Department, and outside of normal business processes for providing Department services.~~ (3-17-22)

~~02. Confidential Information. Information that may only be used or disclosed as provided by state or federal law, federal regulation, or state rule.~~ (3-17-22)

~~03. Consent. Permission to use or disclose confidential information. Consent may be inferred from the circumstances.~~ (3-17-22)

~~04. Department. The Idaho Department of Health and Welfare.~~ (3-17-22)

~~05. Guardian ad Litem. The person appointed by the court, according to law, to protect the interest of a minor or an incompetent in a case before the court.~~ (3-17-22)

~~06. Health Information. Identifying information about the past, present or future:~~ (3-17-22)

~~a. Physical or mental health or condition of an individual;~~ (3-17-22)

~~b. Provision of health care to an individual; or~~ (3-17-22)

~~c. Payment for health care for an individual.~~ (3-17-22)

~~07. Identifying Information. The name, address, social security number, or other information by which an individual could be identified. Information may also be identifying without a name, based on the context or circumstances of a disclosure.~~ (3-17-22)

~~08. Informal Representative. A person who is not a legal representative, but who is a relative, friend, or other person permitted to communicate with the Department on behalf of an individual. The individual or legal~~

~~representative may give such permission verbally, in writing, or through their conduct. (3-17-22)~~

~~**09. Legal Representative.** The parent of a minor, a guardian, conservator, attorney, or an individual who has an appropriate power of attorney. (3-17-22)~~

~~**10. Minimally Necessary.** The information that is essential to provide benefits or services, and to perform normal business processes of the Department. (3-17-22)~~

~~**11. Need to Know.** Confidential information that is necessary to provide benefits or services, and to perform normal business processes of the Department. (3-17-22)~~

~~**12. Psychotherapy Notes.** Notes recorded in any format by a mental health professional that documents or analyzes the content of individual or group counseling sessions, and that are separated from the rest of the individual's medical record. The term "psychotherapy notes" excludes: (3-17-22)~~

~~**a.** Medication prescription and monitoring; (3-17-22)~~

~~**b.** Counseling session start and stop times; (3-17-22)~~

~~**c.** Types and frequencies of treatment furnished; (3-17-22)~~

~~**d.** Results of clinical tests; and (3-17-22)~~

~~**e.** Any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. (3-17-22)~~

011. DEFINITIONS FOR VITAL STATISTICS.

The definitions provided in Subsection 011 of these rules apply to Vital Statistics and to the disclosure provisions of Section 39-270, Idaho Code. (3-17-22)

~~**01. Authorized Representative.** An attorney, physician, funeral director, a legally designated agent, or an entity whose purpose for obtaining a vital record is to pay direct benefits to a person with a direct and tangible interest defined in Subsection 011.03 of this rule. (3-17-22)()~~

~~**02. Certificate.** A certificate of birth, death, stillbirth, miscarriage, marriage, or divorce, filed pursuant to law, excluding information contained in the statistical section of any record. (3-17-22)~~

~~**03. Individuals with a Direct and Tangible Interest.** Individuals who have a direct and tangible interest in a vital record are: (3-17-22)~~

~~**a.** The registrant and that person's spouse, children, parents, grandparents, grandchildren, siblings, or guardian; (3-17-22)~~

~~**b.** Any other person who demonstrates that the record is needed for the determination or protection of that person's property right; (3-17-22)~~

~~**c.** An authorized representative of any of these individuals; (3-17-22)~~

~~**d.** The surviving next-of-kin if a deceased registrant has no other surviving family member listed in this subsection; (3-17-22)~~

~~**e.** The Idaho Attorney General, and state and federal prosecuting attorneys, if such attorney submits an affidavit affirming that the record is necessary in the furtherance of the attorney's official law enforcement duties, is not reasonably available from another source, and that reasonable steps will be taken to preserve the confidentiality of the record; (3-17-22)~~

~~**f.** Any person, upon the order of an Idaho court of competent jurisdiction, where the court finds that~~

disclosure of the record is necessary in the interests of justice; and (3-17-22)

g. Any person with the right to control the disposition of remains of a deceased person or to determine provisions not clearly covered in a prearranged funeral plan as authorized in Section 54-1142(1) Idaho Code, in accordance with Section 39-270(b), Idaho Code. (3-17-22)

043. Parent. Does not include ~~a biological parent~~ an individual whose parental rights have been terminated with respect to a specific child. (3-17-22)()

054. Public Health. The science and ~~art~~ practice of: (3-17-22)()

a. Preventing disease, prolonging life, or promoting health ~~and efficiency through organized community effort for the sanitation of the environment~~ within populations and communities; (3-17-22)()

b. ~~The~~ Control of communicable infections; (3-17-22)()

c. ~~The~~ Education of the individual in ~~personal hygiene~~ healthy choices; (3-17-22)()

d. ~~The organization of medical and nursing services for the~~ Promotion of early diagnosis and ~~preventive treatment~~ prevention of disease; and (3-17-22)()

e. ~~The development of the social machinery to~~ overall support and participation in systems that ensure everyone a standard of living ~~adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize their birthright of~~ to maintain health and longevity. (3-17-22)()

06. Putative Father. The biological father of a child as identified by himself, the natural mother, an adoption agency, or a court. (3-17-22)

07. Registrar. The state Registrar as defined in Section 39-241(18), Idaho Code. The mailing and street address for the state Registrar is Bureau of Vital Records and Health Statistics, 450 W. State St., 1st Floor, PO Box 83720, Boise, Idaho 83720-0036. (3-17-22)

085. Research. Organized scientific inquiry or examination of data in order to discover and interpret facts. (3-17-22)

096. Statistical Purposes. The collection, analysis, interpretation and presentation of masses of non-identifying numerical information. (3-17-22)

012. --049. (RESERVED)

GENERAL CONSENT AND DISCLOSURE REQUIREMENTS **(Sections 050-199)**

050. CONSENT TO GATHER, USE AND DISCLOSE INFORMATION:

~~When individuals, legal representatives or informal representatives sign an application, they consent for the Department to gather, use and disclose information as needed for an individual to receive Department benefits or services. If none of these individuals provides a consent on an application, service may be denied. An informal representative may only consent to the disclosure of confidential information when permitted by these rules.~~

(3-17-22)

051. AUTHORIZATION FOR THE USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION:

~~An authorization for the use and disclosure of confidential information must be in writing, and identify the individual who is the subject of the record.~~

(3-17-22)

01. Content of Authorization. ~~An authorization must be dated and signed by the individual or legal representative, and:~~

(3-17-22)

- a.** Identify the specific information involved; (3-17-22)
- b.** State the duration of the authorization, defined by a specific date or the description of an event; (3-17-22)
- c.** Identify the recipient of the information; and (3-17-22)
- d.** State the purpose for the authorization, or state that it is, "At the request of the individual," or similar wording. (3-17-22)
- 02. Defective Authorization.** An authorization must not be acted upon if the authorization has expired or has been revoked, or if any essential information is omitted or is false. (3-17-22)
- 03. Authorization for the Use and Disclosure of Health Information.** An authorization for the use and disclosure of health information must contain the content listed in Subsection 051.01 and the statements required by 45 CFR 164.508(c)(2). (3-17-22)
- 04. Psychotherapy Notes.** Psychotherapy notes that are separate from the rest of an individual's record may not be used or disclosed without an authorization except to the originator of the notes for treatment or to defend the Department in a legal action brought by the individual. (3-17-22)
- 05. Revocation of an Authorization.** An individual or legal representative may revoke an authorization at any time by submitting a written request at any Department office. (3-17-22)
- 06. Effect on Benefits and Services.** An individual's refusal to provide an authorization does not affect the receipt of benefits or services the individual would otherwise receive. (3-17-22)
- 07. Copy of Authorization.** The Department will provide a copy of the signed authorization to the individual or legal representative. (3-17-22)
- 052.—074. (RESERVED)**
- 075. USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION.**
Without a consent or an authorization, no one may use or disclose health or other confidential information except as provided in Section 100 of this chapter. With a consent or an authorization, confidential information will be used or disclosed only on a need-to-know basis and to the extent minimally necessary for the conduct of the Department's business and the provision of benefits or services, subject to law and the exceptions listed in these rules. Recipients of information must protect against unauthorized disclosure or use of the information for purposes that are not specified in a consent or an authorization. Access to an individual's own records is governed by Section 125 of this chapter. Specific consent and disclosure requirements are identified in Sections 200 through 283 of these rules. (3-17-22)
- 01. Identity.** Any individual who requests to review, copy, restrict or amend confidential information, or to sign an authorization, must provide verification of identity, and where appropriate, present proof that the individual is a legal representative of the subject of the record. Except for verifications or requests for certified copies of vital records, requests submitted by mail must be notarized if necessary to identify the individual's signature. (3-17-22)
- 02. Order of Court or Hearing Officer.** If information is subpoenaed in a civil, criminal or administrative action, the Department will provide such information as would be disclosed with a public records request, without an order from the court or hearing officer. Alternatively, the Department may submit the record with a request for a review solely by the judge or hearing officer, and an order appropriately limiting its use by the parties. If Department staff have reason to believe that release of a record through a public records request may be detrimental to any individual, the Department may seek a protective order. (3-17-22)
- 03. Referent.** Unless the individual is a witness in litigation, identifying information must not be disclosed about an individual who reported concerns relating to any Department responsibility, including: (3-17-22)

- a.** Fraud; (3-17-22)
- b.** Abuse, neglect or abandonment of a child; (3-17-22)
- c.** Abuse, neglect or abandonment of a vulnerable adult; (3-17-22)
- d.** Concerns about the mental health of another; and (3-17-22)
- e.** Certified family homes, unless the complainant consents to disclosure in writing or disclosure is required in any administrative or judicial proceeding, in compliance with Section 74-105(16), Idaho Code. (3-17-22)
- 04. Collateral Contact.** Identifying information must not be disclosed about individuals who are not the subject of the record and who provide information to the Department in the ordinary course of business. (3-17-22)
- 05. Alternative Communication.** The Department, contractors and providers must comply with an individual's request that confidential information be communicated by alternative means of delivery unless it is administratively difficult to do so or the request is unreasonable. If approved, all information from a Department program will use the same alternative means of delivery after the request is received and recorded. (3-17-22)
- 06. Restriction on Disclosure of Health Information.** (3-17-22)
- a.** An individual may request in writing that use or disclosure of health information be restricted. The Department will respond in writing, and may deny the request if: (3-17-22)

 - i.** Disclosure is required; (3-17-22)
 - ii.** Necessary for the safety of the individual or others; (3-17-22)
 - iii.** Necessary for the provision of services, benefits or payment; or (3-17-22)
 - iv.** The restriction is unreasonable. (3-17-22)
- b.** The uses and disclosures of confidential information are subject to a restriction after it is received and recorded by the Department. Department employees, contractors, and the individual may request the Department to terminate the restriction. The Department will notify the individual of its response to a request to terminate a restriction. (3-17-22)
- 07. Discovery.** Records will be provided only in response to valid discovery in any federal or state criminal, civil or administrative proceeding, as required by the Public Records Act, Section 74-115(3), Idaho Code. (3-17-22)
- 076.—099. (RESERVED)**
- 100. EXCEPTIONS TO REQUIREMENT FOR AUTHORIZATION.** Confidential information will be released without an authorization to individuals and entities in compliance with a court order, or if they are legally authorized to receive it. The following are exceptions to the requirement for an authorization: (3-17-22)

 - 01. Advocates and Guardians.** Federally-recognized protection and advocacy agencies or duly appointed guardians ad litem have access to an individual's file as necessary to perform their legal functions. Guardians ad litem have access to records as provided in Section 16-1634, Idaho Code, except for: (3-17-22)

 - a.** Drug abuse and sickle cell anemia records maintained by the Veteran's Administration (VA), as required by 38 USC Section 7332; (3-17-22)
 - b.** Claims under laws administered by the VA as required by 38 USC Section 3301; and (3-17-22)

~~e.~~ Drug abuse prevention programs that receive federal assistance, as required by 42 USC Section 290ee-3. (3-17-22)

~~02. Licensure.~~ In compliance with Section 74-106(9), Idaho Code, records will be released if they are part of an inquiry into an individual's or organization's fitness to be granted or retain a license, certificate, permit, privilege, commission or position. These records will otherwise be provided in redacted form as required by law or rule. (3-17-22)

~~03. Fugitives and Missing Persons.~~ (3-17-22)

~~a.~~ A state or local law enforcement officer may receive the current address of any cash assistance recipient who is a fugitive felon, in compliance with Section 56-221, Idaho Code. (3-17-22)

~~b.~~ The following health information may be disclosed to a law enforcement officer for the purpose of identifying or locating a suspect, fugitive, material witness or missing person: (3-17-22)

~~i.~~ Name and address; (3-17-22)

~~ii.~~ Date and place of birth; (3-17-22)

~~iii.~~ Social security number; (3-17-22)

~~iv.~~ Blood type and rh factor; (3-17-22)

~~v.~~ Type of injury; (3-17-22)

~~vi.~~ Date and time of treatment or death, if applicable; and (3-17-22)

~~vii.~~ Distinguishing physical characteristics. (3-17-22)

~~e.~~ DNA, dental records, or typing, samples or analysis of body fluids or tissue must not be disclosed. (3-17-22)

~~04. Duty to Warn or Report.~~ Confidential information may be released without an authorization if necessary under a legal duty to warn or to report. (3-17-22)

~~05. Department Business, Monitoring and Legal Functions.~~ Department employees and contractors may use and disclose records as necessary to perform normal business functions, including health treatment, audit and quality improvement, investigation of fraud and abuse, establishment of overpayments and recoupment, public health, or other functions authorized by law. Information will be made available to state and federal auditors and compliance monitors. Confidential information will be provided to counsel as needed to evaluate, prepare for and represent the Department in legal actions. (3-17-22)

~~06. Emergencies.~~ Confidential information may be disclosed to qualified medical personnel to the extent necessary to respond to a medical emergency that requires immediate attention. (3-17-22)

~~07. Multidisciplinary Staffing.~~ Confidential information may be disclosed to employees of the Department, law enforcement, and other appropriate individuals to participate in a multidisciplinary team evaluation of child protection cases under Section 16-1617, Idaho Code, or interdisciplinary Department staffing of services for an individual. All individuals who participate in such staffing must not redisclose the information and must comply with any other pertinent statute, rule or regulation. (3-17-22)

~~08. Collaborative Staffing.~~ Confidential information may be disclosed in staffing by the Department and other individuals or entities if all participants are involved with the same or similar populations and have an equal obligation or promise to maintain confidentiality. Disclosure of information in inter-agency staffing must be necessary to coordinate benefits or services, or to improve administration and management of the services.

~~Confidential information may be disclosed only on a need-to-know basis and to the extent minimally necessary for the conduct of the staffing. All individuals who participate in such staffing must not redisclose the information except in compliance with any other pertinent statute, rule or regulation.~~ (3-17-22)

~~**09. Elected State Official.** As provided by Section 16-1629(6), Idaho Code, any duly elected state official carrying out their official functions may have access to child protection records of the Department, and must not redisclose the information.~~ (3-17-22)

~~**10. Child Protection Agency.** A legally mandated child protection agency may provide information necessary to investigate a report of known or suspected child abuse or neglect, or to treat a child and family who are the subjects of the record.~~ (3-17-22)

~~**11. Legally Authorized Agency.** An agency will be provided appropriate information if the agency is legally responsible for or authorized to care for, treat or supervise a child who is the subject of the record.~~ (3-17-22)

~~**12. Informal Representatives.** Informal representatives may be permitted to receive and deliver information on behalf of an individual, and may be given health information if the informal representative is directly involved with the individual's care. Confidential information may be withheld in whole or part if professional staff determines that disclosure is not in the best interest of the individual, based on the circumstances and their professional judgment. The Department will not disclose information that is prohibited from being disclosed by these rules or any other legal requirement.~~ (3-17-22)

~~**13. Law Enforcement.** Any federal, state, or local law enforcement agency, or any agent of such agency, may be permitted access to information as needed in order to carry out its responsibilities under law to protect children from abuse, neglect, or abandonment.~~ (3-17-22)

~~**101. ABUSE, NEGLECT, OR DOMESTIC VIOLENCE.**~~

~~Health information may be disclosed to a law enforcement officer if the victim of abuse, neglect, or domestic violence agrees to the disclosure.~~ (3-17-22)

~~**01. Incapacity of Victim.** If the victim is unable to agree because of incapacity, health information will be disclosed if the officer states:~~ (3-17-22)

- ~~**a.** That the information is not intended to be used against the victim; and~~ (3-17-22)
- ~~**b.** That immediate enforcement activity would be materially and adversely affected by waiting for the victim's agreement.~~ (3-17-22)

~~**02. Judgment of Professional Staff.** The victim must be promptly informed that a report to law enforcement has been or will be made unless in the judgment of professional staff:~~ (3-17-22)

- ~~**a.** Informing the victim would place them at risk of serious harm; or~~ (3-17-22)
- ~~**b.** The probable perpetrator of the abuse, neglect or domestic violence would be the recipient of the report, and disclosure would not be in the victim's best interest.~~ (3-17-22)

~~**102. VICTIM OF OTHER CRIME.**~~

~~Health information may be disclosed in response to a law enforcement official's request about a victim or suspected victim of a crime other than those listed in Section 101 of these rules, if the individual agrees to the disclosure.~~ (3-17-22)

~~**01. Incapacity of Victim or Emergency Circumstance.** If the individual is unable to agree because of incapacity or emergency circumstance, health information will be disclosed if the official states that the information is needed to determine whether a violation of law has occurred, and that it is not intended to be used against the individual.~~ (3-17-22)

~~**02. Best Interest of the Individual.** The officer must also represent that immediate enforcement~~

activity would be materially and adversely affected by waiting for the individual's agreement. Professional staff must agree that disclosure is in the best interest of the individual. (3-17-22)

~~103. SERIOUS THREAT TO HEALTH OR SAFETY.~~

~~Subject to the restrictions in this rule, health information may be used or disclosed if necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. Disclosure must be based on actual knowledge or credible information from a person with apparent knowledge or authority. Disclosure will be made only to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. (3-17-22)~~

~~**01. Apprehension by Law Enforcement.** Health information may be disclosed as necessary to law enforcement to identify or apprehend an individual. Disclosure is limited to an admission that an individual participated in a violent crime if it is reasonable to believe that serious physical harm has been caused to the victim. (3-17-22)~~

~~**02. Escape From Law Enforcement.** Health information may be disclosed as necessary for law enforcement to identify or apprehend an individual where it appears from all the circumstances that the individual has escaped from a correctional institution or lawful custody. (3-17-22)~~

~~**03. Prohibition on Disclosure.** Disclosure of an admission of participation in a violent crime is prohibited if the information is learned in the course of treatment to affect the individual's tendency to commit the criminal conduct, or through a request by the individual to initiate such treatment. (3-17-22)~~

~~104. REPORTING OF CRIME ON PREMISES.~~

~~Health information may be disclosed to a law enforcement official if the information constitutes evidence of criminal conduct that occurred on the Department's premises. (3-17-22)~~

~~105. REPORTING CRIME IN EMERGENCIES.~~

~~If a Department employee is providing emergency health care off the Department's premises, health information may be disclosed if necessary to alert law enforcement to a crime; the location of the crime or victim; and the identity, description and location of the perpetrator. If the crime involves abuse, neglect or domestic violence, the requirements of Section 101 of this chapter apply. (3-17-22)~~

~~106.—124. (RESERVED)~~

~~125. ACCESS TO AN INDIVIDUAL'S OWN RECORD.~~

~~An individual who is at least fourteen (14) years old, or a legal representative, may review and obtain a copy of Department records that pertain to the individual, subject to the exceptions listed in Subsections 125.01 through 125.04 of these rules. Requests must be in writing, identifying the individual whose record is sought, and the record or information requested. The principles of disclosing only minimally necessary information on a need-to-know basis do not apply to a request for an individual's own records. The following information must not be disclosed: (3-17-22)~~

~~**01. Children's Mental Health.** Records of a child's mental health services must not be disclosed to the child when a physician or other mental health professional has noted that disclosure would be damaging to the child, unless access is ordered by a court according to Section 16-2428, Idaho Code. (3-17-22)~~

~~**02. Legal Action.** No disclosure will be made to an individual of information compiled in an ongoing investigation, that is exempt from disclosure, or that relates to adoption. Information compiled in reasonable anticipation of litigation that is not otherwise discoverable must not be disclosed. Information compiled for use in a civil, criminal, or administrative proceeding to which the individual is a party must not be disclosed except in compliance with valid discovery. (3-17-22)~~

~~**03. Clinical Laboratories.** There will be no disclosure of information maintained by a clinical laboratory except as authorized by the provider who ordered the test or study, in compliance with 42 USC 263a. (3-17-22)~~

~~**04. Confidential Information.** Health and other confidential information will not be disclosed to the individual if a licensed professional in an appropriate discipline determines that disclosure is likely to endanger the~~

life or physical safety of the individual or another person. Disclosure to a legal representative will be denied if there is a professional determination that access by the representative is likely to cause substantial harm to the subject of the record or another person. (3-17-22)

~~126.—149.~~ (RESERVED)

~~150. AMENDMENT OF RECORD.~~

Unless otherwise provided by law, individuals may request in writing to amend the content of a record created by the Department. The Department will respond in writing within ten (10) days, granting or denying the amendment. A record created by a third party will not be amended by the Department. (3-17-22)

~~01. Amendment of Health Information.~~ Once an amendment regarding health information is approved and recorded, the Department will provide the amended health information when the record is disclosed in the future. If an amendment of health information is denied, the individual may provide a written response, which the Department may rebut in writing to the individual. Upon request, documentation of all the records involved in the denial will be provided whenever that information is disclosed in the future. (3-17-22)

~~02. Updating Identifying Information.~~ Name and address changes, and similar updates of information in Department files will be made without using the amendment process. (3-17-22)

~~151.—174.~~ (RESERVED)

~~175. REPORT OF DISCLOSURES OF HEALTH INFORMATION.~~

~~01. Documented Disclosures.~~ The following disclosures of identifying health information for a purpose other than providing health treatment, payment or operations will be documented: (3-17-22)

- ~~a.~~** Required by law; (3-17-22)
- ~~b.~~** Public health activities; (3-17-22)
- ~~c.~~** Related to victims of abuse, neglect or domestic violence; (3-17-22)
- ~~d.~~** Health care oversight; (3-17-22)
- ~~e.~~** Judicial and administrative proceedings; (3-17-22)
- ~~f.~~** Correctional institutions or custodial law enforcement situations; (3-17-22)
- ~~g.~~** Coroners, medical examiners, and funeral directors; (3-17-22)
- ~~h.~~** Organ or tissue donations; (3-17-22)
- ~~i.~~** Research; (3-17-22)
- ~~j.~~** To avert a serious threat of health and safety; and (3-17-22)
- ~~k.~~** Specialized government functions such as national security or intelligence. (3-17-22)

~~02. Documentation of Disclosure.~~ Documentation will identify when the disclosure occurred, to whom, what information was disclosed and for what purpose. (3-17-22)

~~03. Maintenance of Documentation.~~ The Department maintains documentation of these disclosures of health information for six (6) years. (3-17-22)

~~04. Request for Report of Disclosures.~~ An individual or legal representative may receive one (1) free report of disclosures per calendar year for six (6) years beginning April 14, 2003. Additional requests for a report of

disclosures are processed as public record requests, and may be subject to fees. (3-17-22)

~~05. Pending Investigation.~~ The Department must suspend reporting of a disclosure of health information at the request of any federal, state or local entity that is conducting an investigation related to the oversight of health care, illegal discrimination, licensing, certification or accreditation. If the request is verbal, the suspension will terminate after thirty (30) days unless the request is renewed in writing. (3-17-22)

~~176.—189. (RESERVED)~~

~~190. RECORDS OF DECEDENTS.~~

Records of decedents are confidential for as long as the Department maintains the records, except as needed by: (3-17-22)

01. Law Enforcement. If there is suspicion that the death was the result of criminal conduct. (3-17-22)

02. Coroners and Medical Examiners. Information may be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. (3-17-22)

03. Funeral Directors. Confidential information may be given to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary to carry out their duties, confidential information may be disclosed to funeral directors prior to and in reasonable anticipation of the individual's death. (3-17-22)

04. Personal Representatives. While records are maintained, the same confidentiality requirements apply to the personal representative of the estate or other legal representative of the deceased individual. Information may be disclosed to such representatives only to the extent necessary to perform their legal function, (3-17-22)

05. Family Members and Others. The Department may disclose health information to a family member, other relative, a close personal friend of the deceased individual, or any other person identified by the deceased individual. Information provided must be directly related to such person's involvement with the individual's care or payment for health care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the Department. (3-17-22)

~~191. DATA FOR RESEARCH OR OTHER PURPOSES.~~

Records that contain non-identifying information may be disclosed for Department-approved research or other purposes without a written authorization. (3-17-22)

~~192.—199. (RESERVED)~~

~~SPECIFIC CONSENT AND DISCLOSURE REQUIREMENTS~~
~~(Sections 200-283)~~

~~200. ABORTION FOR MINORS.~~

Consent for an abortion for a minor is governed by Section 18-609A, Idaho Code. (3-17-22)

~~201. ABUSE, NEGLECT OR DOMESTIC VIOLENCE.~~

Abuse, abandonment or neglect of a minor is required to be reported in compliance with Section 16-1605, Idaho Code. Abuse, neglect or exploitation of adults is governed by Section 39-5303, Idaho Code. An exception to the physician/patient privilege for domestic violence is contained in Section 9-203, Idaho Code. (3-17-22)

~~202. ADOPTION.~~

Disclosure of adoption records is governed by the provisions of Sections 74-105(6), 16-1501, 39-258, 39-259A, and 39-7501 through 39-7905, Idaho Code. Consent to adoption by children who are more than twelve (12) years old, by parents and by others, is governed by Section 16-1504, Idaho Code. (3-17-22)

203.—209. (RESERVED)

210. CHILD PROTECTION.

It shall be the policy of the Idaho Department of Health and Welfare to provide information to the maximum extent possible to carry out the department's responsibility under law to protect children from abuse and neglect and to facilitate child and family services. The Department, upon request will disclose information from child protection records in its possession pursuant to Section 74-105(7), Idaho Code. Disclosure of Department records under the Child Protective Act is governed by Section 16-1629(6), Idaho Code, and Idaho Court Administrative Rule 32. Court records of Child Protective Act proceedings are governed by Section 16-1626, Idaho Code. Pertinent federal laws and regulations include 42 USC 5106a. (7-1-25)

01. Child Fatalities. In accordance with 42 USC 5106a(b)(2)(B)(x), the Department will disclose non-identifying summary information to the Statewide Child Fatality Review Team, established by the Governor's Task Force on Children at Risk, regarding child fatalities that were determined to be the result of abuse, neglect, or abandonment. (3-17-22)

02. Public Disclosure. The Department has the discretion to disclose child-specific information under this rule when the disclosure is not in conflict with the child's best interests and one (1) or more of the following applies: (3-17-22)

a. Identifying information related to child-specific abuse, neglect, or abandonment has been previously published or broadcast through the media; (3-17-22)

b. All or part of the child-specific information has been publicly disclosed in a judicial proceeding; or (3-17-22)

c. The disclosure of information clarifies actions taken by the Department on a specific case. (3-17-22)

211. CHILDREN'S MENTAL HEALTH.

Consent to voluntary treatment for a minor with serious emotional disturbance, emergency and involuntary treatment are governed by the Children's Mental Health Services Act, Title 16, Chapter 24, Idaho Code. Section 16-2428, Idaho Code, describes requirements for confidentiality. (3-17-22)

212.—219. (RESERVED)

220. HARD-TO-PLACE CHILDREN.

The Department disseminates information to prospective adoptive families and families who wish to be appointed legal guardians of a child in the state's custody, as to the availability of hard-to-place children, adoption and guardianship procedures, and the existence of financial aid to adoptive families and guardians of hard-to-place children, in compliance with Section 56-804, Idaho Code. (3-17-22)

221. HOSPITAL RECORDS.

Records of hospitalization in a state facility are governed by Sections 39-1392b, 39-1392e and 39-1394, Idaho Code. (3-17-22)

222. HUMAN RESOURCES.

Disclosure of employee information is governed by Section 74-106(1), Idaho Code. (3-17-22)

223. INFANT/TODDLER PROGRAM.

Consent to early intervention services and confidentiality of records that relate to the Infant/Toddler program are governed by the Individuals with Disabilities Education Act (IDEA), 20 USC 1414(a)(1)(C) and (c)(3), and 20 USC 1415(b)(3); the Family Educational Rights and Privacy Act (FERPA), 20 USC 1232g; and 34 CFR 303.400, 34 CFR 303.500 and 34 CFR part 99. (3-17-22)

224.—229. (RESERVED)

230. ~~MEDICAL CARE.~~

~~Consent to apply for services or treatment is governed by Title 39, Chapter 45, Idaho Code, for hospital, medical, dental or surgical care, treatment or procedure.~~ (3-17-22)

231.—239. (RESERVED)

240. ~~MENTAL ILLNESS.~~

~~Records of assessment, treatment, and commitment or hospitalization of individuals with mental illness are governed by Sections 66-318, 66-348, 66-355, 66-329(9), and 66-337, Idaho Code.~~ (3-17-22)

241. ~~MINOR'S CONSENT REGARDING INFECTIOUS, CONTAGIOUS OR COMMUNICABLE DISEASE.~~

~~Section 39-3801, Idaho Code, governs consent to treatment for infectious, contagious or communicable disease by a minor who is at least fourteen (14) years of age.~~ (3-17-22)

242. ~~SPECIFIC REQUIREMENTS -- PROTECTION AND ADVOCACY AGENCIES.~~

~~A protection and advocacy system for individuals who have a developmental disability is created by 42 USC 15042 et seq.; for individuals with mental illness, by 42 USC 10801. Advocacy for adult protection is governed by Sections 39-5307 and 39-5308, Idaho Code.~~ (3-17-22)

243.—249. (RESERVED)

250. ~~SUBSTANCE ABUSE.~~

~~Consent to treatment and confidentiality of alcohol and drug abuse patient records are governed by 42 CFR 2.12 through 2.67, and Sections 37-2743, 37-3102, 39-307, and 39-308, Idaho Code.~~ (3-17-22)

01. ~~Drug Abuse.~~ A medical practitioner will not disclose identifying information, treatment or request for treatment, to any law enforcement officer or agency or in any proceeding, in compliance with Sections 37-2743 and 37-3102, Idaho Code. (3-17-22)

02. ~~Age Sixteen and Over.~~ Information regarding substance abuse treatment of an individual who is at least age sixteen (16) years old will not be disclosed to a parent or guardian unless authorized by the individual, in compliance with Section 37-3102, Idaho Code, and 42 CFR 2.14. Individuals who are at least sixteen (16) years old may consent to substance abuse treatment. (3-17-22)

251.—259. (RESERVED)

260. ~~TERMINATION OF PARENTAL RIGHTS.~~

~~Disclosure of information regarding the termination of parental rights is governed by Section 16-2013, Idaho Code.~~ (3-17-22)

261.—269. (RESERVED)

270. ~~VENEREAL DISEASES.~~

~~Disclosures of health information pertaining to the control of venereal diseases, including Human Immunodeficiency Virus (HIV), is governed by Title 39, Chapter 6, Idaho Code.~~ (3-17-22)

271.—279. (RESERVED)

280. ~~VITAL STATISTICS -- VERIFICATION OF DATA.~~

01. ~~Verifications.~~ The Registrar will confirm or deny the presence and accuracy of data already known to a governmental agency that requests information from a vital record. Such verifications may be conducted by telephone for Idaho state agencies. Other requests for verification require a signed application on forms provided or approved by the Registrar, and a copy of the front and back of signed photo identification or such other information as the Registrar requests. Verifications may also be conducted via Department automated systems approved by the Registrar. (3-17-22)

02. Administrative Fact of Death Verifications. Upon agreement in writing to such conditions as the Registrar may impose, the Registrar may compare Idaho state agency administrative data to Idaho death data and return an indication of death, also known as fact of death verification, for administrative purposes only. (3-17-22)

03. Verifications to Protect a Person's Property Right. The State Registrar may approve electronic fact of death verification by entities seeking to determine or protect a person's property right. (3-17-22)

281. VITAL STATISTICS: DISCLOSURE FOR RESEARCH, PUBLIC HEALTH OR STATISTICAL PURPOSES.

Upon agreement in writing to such conditions as the Registrar may impose, the Registrar may permit the use of data from vital statistics records for research, public health or statistical purposes. The Registrar may deny a request for access to identifying information if the Registrar determines that the benefits would be outweighed by the possible adverse consequences to those individuals whose records would be used. (3-17-22)

~~**282. VITAL STATISTICS: REGISTRY OF PUTATIVE FATHERS.**~~

~~Except by Idaho court order or in accordance with the provisions of Section 16-1513, Idaho Code, information acquired by the confidential registry of putative fathers will not be disclosed.~~ (3-17-22)

282. (RESERVED)

283. VITAL STATISTICS: PROCEDURES FOR REQUESTING INFORMATION.

Individuals who request access to, information from, or copies of vital records must present a signed application on forms provided or approved by the Registrar, and a copy of the front and back of signed photo identification or such other information as the Registrar requests. ~~Minors who are less than fourteen (14) years old may receive certified copies of vital records that pertain to them if they present the required information.~~ (3-17-22)()

01. Expedited Copy. An expedited certified copy of a vital record may be issued using Department automated systems. (3-17-22)

02. Certified Copy. When a certified copy is issued, it is certified as a true copy or abstract of the original vital record by the ~~officer who has custody of the record~~ Registrar. The certified copy will include the date issued, the Registrar's signature or an authorized facsimile thereof, and the seal of the issuing office ~~and excluding information contained in the statistical section of any record~~. Full or short form certified copies of vital records may be ~~made by mechanical, electronic or other reproduction processes~~ issued. (3-17-22)()

~~**284. WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM.**~~

~~WIC information may be used and disclosed only for the purpose of establishing the eligibility of WIC applicants and participants for health and welfare programs.~~ (3-17-22)

~~**285**~~4. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.02 – FOSTER CARE LICENSING

DOCKET NO. 16-0602-2501

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), 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:

During the 2025 Idaho Legislative Session House Bill 245 was passed and signed into law which increased the maximum age of extended foster care from age 21 to 23 years old. As such, the rule needed to be updated by July 1st to be in congruence with statute. This temporary and proposed rule also addresses the second component of House Bill 245 which called on the Department to make a separate path for licensure for kin. Finally, this rule makes changes to the application process for foster parents which grant the Department the ability to deny an application in the event of the preponderance of evidence and the underlying facts and circumstances indicating that a prior offense has been committed. 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 July 2nd, 2025, Idaho Administrative Bulletin, [Vol. 25-7, pages 67 through 77](#).

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.

DATED this 31st day of July, 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

**THE FOLLOWING NOTICE PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is July 1st, 2025.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Wednesday, July 16, 2025 4:00 PM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=mb2272ba0917e189d2dff63ab211af5a6
Join by meeting number Meeting number (access code): 2831 291 3655 Meeting password: BMw2g3Quin4 Meeting password when dialing from a phone or video system: 26924378
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)
Thursday, July 17, 2025 10:00 AM (MT)
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m4ee995425b29c39ad0bd5110ebde51a3
Join by meeting number Meeting number (access code): 2830 341 3870 Meeting password: 233Eq2H4WFP Meeting password when dialing from a phone or video system: 23337244
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)

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:

During the 2025 Idaho Legislative Session House Bill 245 was passed and signed into law which increased the maximum age of extended foster care from age 21 to 23 years old. As such, the rule needed to be updated by July 1st to be in congruence with statute. This temporary and proposed rule also addresses the second component of House Bill 245 which called on the Department to make a separate path for licensure for kin. Finally, this rule makes changes to the application process for foster parents which grant the Department the ability to deny an application in the event of the preponderance of evidence and the underlying facts and circumstances indicating that a prior offense has been committed.

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

This temporary and proposed rule is being published to comply with the changes made to foster care in House Bill 245 from the 2025 legislative session which are set to take effect on July 1st, 2025. Furthermore, the changes made to this chapter for kin licensure will allow for a quicker and less burdensome process for kin of foster children to become licensed foster parents.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this is in direct response to a bill that passed the legislature this year, during which time input was taken from the public in both the House and Senate committees.

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 Jared Larsen at DHWRules@dhw.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 July 23rd, 2025.

DATED this 28th day of May, 2025.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0602-2501

16.06.02 – FOSTER CARE LICENSING

000. LEGAL AUTHORITY.

Sections 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8) Idaho Code, ~~authorize the Department and the Board to adopt and enforce rules for licensing foster homes.~~ (7-1-25)()

001. – 009. (RESERVED)

010. DEFINITIONS.

~~In addition to those terms used in Title 39, Chapter 12, the following apply:~~ The terms listed in this section apply to this chapter. Terms not defined below are defined in Title 39, Chapter 12, and IDAPA 16.06.01. (7-1-25)()

01. Caregiver. A foster parent with whom a child in foster care has been placed or a designated official for a child care institution in which a child in foster care has been placed. (7-1-25)

02. Child. Includes individuals age eighteen (18) to twenty-~~onethree~~ (24) who are ordered into or voluntarily entered Extended Foster Care through the Department. (7-1-25)()

03. Department. The Idaho Department of Health and Welfare or its authorized representatives. (7-1-25)

04. Foster Home. Includes both foster homes and relative foster homes as set forth in Idaho Code. (7-1-25)

05. Foster Parent. ~~A Licensed~~ person(s) residing in a private home under their direct control ~~to whom a foster care license has been issued.~~ (7-1-25)()

06. Household Member. Any person, other than a foster child, who resides in, or on the property of, a foster home. (7-1-25)

07. Medical Professionals. Persons who have received a degree in nursing or medicine and are licensed as a registered nurse, nurse practitioner, physician's assistant, or medical doctor. (7-1-25)

08. Noncompliance. Violation of, or inability to meet, the requirements of these rules or terms of licensure. (7-1-25)

09. Plan of Correction. The detailed procedures and activities developed between the Department and caregiver required to bring a foster family into conformity with these rules. (7-1-25)

10. Restraint. Physical interventions to control the range and motion of a child. (7-1-25)

11. Supervision. ~~Is defined as b~~ Being within sight and normal hearing range of ~~the a~~ child ~~or children~~ being cared for. (7-1-25)()

011. – 101. (RESERVED)

102. DISPOSITION OF APPLICATIONS.

The Department will expeditiously initiate action on each completed application within one (1) business day after receipt that addresses each requirement for the specific type of home. (7-1-25)

01. Approval of Application. The Department will issue a license to any foster home complying with these rules. (7-1-25)

02. Regular License. The Department will issue a regular license to any foster home complying with

these rules and will specify the terms of licensure, ~~such as:~~ (7-1-25)()

- a. The number of children who may receive care at any one (1) time; and (7-1-25)
- b. Age range and sex if there are conditions in the foster home making such limitations necessary; (7-1-25)
- c. The regular license for a foster home is in effect for one (1) year from the date of issuance unless suspended or revoked earlier; (7-1-25)
- d. If the license for a foster home is for a specific child, the name of that child will be shown on the foster home license; (7-1-25)

03. Kin-specific License. A license for kin to become foster parents through a separate and expedited path. To qualify, applicants must: ()

- a. Have a relationship with a foster child as described in Idaho law; ()
- b. Receive a background check clearance in accordance with this chapter; and ()
- c. Complete an abbreviated kin caregiver assessment focused solely on determining kin family's ability to meet the child(ren)'s needs and how the Department can support the needs of kin and the child(ren). ()

04. Limited License. May be issued for the care of a specific child in a home which may not meet the requirements for a license, provided: (7-1-25)

- a. The child is already in the home and has formed strong emotional ties with the foster parents; and (7-1-25)
- b. It can be shown that the child's continued placement in the home would be more conducive to their welfare than removal to another home. (7-1-25)

05. Denial of Application. If an application is denied, a signed letter will be sent ~~directly~~ to the applicant by registered or certified mail, advising the applicant of the denial and stating the basis for such denial. An applicant whose application has been denied may not reapply until one (1) year after the date ~~on the denial of application of denial.~~ (7-1-25)()

06. Failure to Complete Application Process. ~~Failure to complete the application process within six (6) months from the original date of application will result in vacation of the application. An application will be deemed vacated if the application process is not completed within six (6) months of the original date of application.~~ (7-1-25)()

07. Facilitating Applications. (7-1-25)

- a. The Department may, within its appropriation, cover reasonable expenses to ensure homes meet the requirements of these rules ~~including the home health and safety requirements and sleeping arrangements.~~ (7-1-25)()

- b. The Department will establish procedures to fast-track applications from candidates who have a successful track record of serving as a foster home in other states. (7-1-25)

08. Reactivating an Idaho License. If less than twelve (12) months has elapsed from the last licensed foster home visit required by Section 39-1217, Idaho Code, the Department may fast-track reactivating the license if the prior licensee: (7-1-25)

- a. Relinquished the license in good standing; and (7-1-25)

- b. Attests to maintaining conformity with the standards established by the Department. (7-1-25)

103. RESTRICTIONS ON APPLICABILITY AND NONTRANSFER.

~~01. Department Issued License. A license is nontransferable and~~ applies only to the foster home or the person and premises designated. Each license is issued in the individual's name, and to the address ~~specified~~ on the application. A license issued in the name of a foster parent applies to the period and services specified in the license. Any change in address renders the license null and void, ~~and the foster parent must immediately return the license to the Department.~~ (7-1-25)()

~~02. Nontransferable. A license is nontransferable from one (1) individual to another or from one (1) location to another.~~ (7-1-25)

~~03. Change in Location. When there is a change in foster home location, the foster home parent must reapply for a license.~~ (7-1-25)

104. (RESERVED)

105. REVISIT AND RELICENSE.

Revisit and relicense studies will document how the foster home continues to meet licensing standards. ~~Consideration must be given to each standard, including a review of the previous study and original application to determine what changes have occurred. A renewal application must be made by the foster home on the Department furnished form and filled out prior to the expiration date of the license in effect. The existing license will, unless officially revoked, remain effective until the Department has acted on the application for renewal. A renewal application must be submitted to the Department prior to the expiration of the existing license. Unless revoked, the existing license will remain effective until the Department has acted on the renewal application.~~ (7-1-25)()

(BREAK IN CONTINUITY OF SECTIONS)

108. ~~(RESERVED)~~ SUSPENSION OR REVOCATION AND TRANSFER OF CHILDREN

01. Suspension. The Department may summarily suspend a foster care license. ()

02. Revocation. The Department may revoke the license of a foster home when the Department determines the home is not in compliance and in the following circumstances: ()

a. Any condition that endangers the health or safety of any child. ()

b. A foster home is not in substantial compliance with these rules. ()

c. A foster home has made little or no progress in correcting deficiencies within thirty (30) days from the date the Department accepted a plan of correction. ()

d. Repeat violation of these rules or Idaho Law. ()

e. Knowingly misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ()

f. Refusal to allow Department representatives full access to the foster home and its grounds, facilities, and records. ()

g. Violating any of the terms of a provisional license. ()

h. The Department concludes that an adult in the foster home fails to live a law-abiding lifestyle and

by a preponderance of the evidence determines the adult has committed a prior offense set forth in IDAPA 16.06.02.201.05. ()

i. The Department may revoke a license even when: ()

(1) The adult received an order under Section 20-525A, Idaho Code, or other equivalent law; a withheld judgment; an order under Section 19-2604, Idaho Code, or other equivalent law; or the record has been sealed. ()

(2) Law enforcement did not investigate, charges were never filed, where charges were dismissed, or where a person was acquitted. ()

ii. Before the Department revokes a license pursuant to this subsection, the Department shall notify the licensee of its intent to revoke the license pursuant to law and give the licensee an opportunity to provide pertinent information about the offense, later good conduct, or treatment before the license is revoked. ()

iii. A clearance from the background check unit does not preclude the revocation of a license under this subsection. ()

~~109. ENFORCEMENT REMEDY OF SUMMARY SUSPENSION AND TRANSFER OF CHILDREN.~~

~~The Department may summarily suspend a foster home license. Children in a foster home require the program to transfer children when the Department has determined a child's health and safety are in immediate jeopardy.~~ (7-1-25)

~~110. ENFORCEMENT REMEDY REVOCATION OF LICENSE AND TRANSFER OF CHILDREN.~~

~~The Department may revoke the license of a foster home when the Department determines the home is not in compliance with these rules. Revocation and transfer of children may occur under the following circumstances:~~ (7-1-25)

~~01. **Endangers Health or Safety.** Any condition that endangers the health or safety of any child.~~ (7-1-25)

~~02. **Not in Substantial Compliance.** A foster home is not in substantial compliance with these rules.~~ (7-1-25)

~~03. **No Progress to Meet Plan of Correction.** A foster home has made little or no progress in correcting deficiencies within thirty (30) days from the date the Department accepted a plan of correction.~~ (7-1-25)

~~04. **Repeat Violations.** Repeat violations of these rules or of Title 39, Chapters 11 and 12, Idaho Code.~~ (7-1-25)

~~05. **Misrepresented or Omitted Information.** A foster home has knowingly misrepresented or omitted information on the application or other documents pertinent to obtaining a license.~~ (7-1-25)

~~06. **Refusal to Allow Access.** Refusal to allow Department representatives full access to the foster home and its grounds, facilities, and records.~~ (7-1-25)

~~07. **Violation of Terms of Provisional License.** A foster home, that has violated any of the terms of a provisional license.~~ (7-1-25)

109. -- 110. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

201. FOSTER PARENT QUALIFICATIONS AND SUITABILITY.

An applicant for licensure as a foster parent must meet the following: (7-1-25)

01. **Age.** Be eighteen (18) years old or older. (7-1-25)
02. **Communication.** Be able to communicate with the child, the children's agency, and health care and other service providers. (7-1-25)
03. **Income and Resources.** Have a defined and sufficient source of income and be capable of managing that income to meet the needs of the foster family without relying on the payment made for the care of a foster child. (7-1-25)
04. **Literacy.** At least one (1) adult caretaker in the home must have functional literacy, ~~such as the ability to read medication labels.~~ (7-1-25)()
05. **Law-Abiding Lifestyle.** Not have committed a prior offense described in IDAPA 16.05.06.210.01. However, the Department may in its discretion deny a license if the applicant has committed a prior offense described in IDAPA 16.05.06.210.02 or 16.05.06.210.03. The commission of any prior offense is proven by a preponderance of the evidence and by the underlying facts and circumstances. ()

202. BACKGROUND CHECKS.

All applicants for a foster care license and other adult members of the household must comply with IDAPA 16.05.06; ~~"Criminal History and Background Checks,"~~ and the following: (7-1-25)()

01. **Change in Household Membership.** By the next working day after another adult begins residing in a foster home, a foster parent must notify the children's agency of the change in household membership and assure that the new adult household member will complete a background check within fifteen (15) days of residence in the foster home. (7-1-25)
02. **Foster Parent's Child Turns Eighteen.** A foster parent's child who turns eighteen (18) and lives continuously in the home is not required to have a background check except as specified in this rule. (7-1-25)
 - a. After turning eighteen (18) years old, if the foster parent's adult child no longer lives in the foster parent's home and subsequently resumes living in the foster home, they will be considered an adult household member and must complete a background check within fifteen (15) days from the date they became an adult household member. (7-1-25)
 - b. If the adult child leaves the foster home for the purpose of higher education or military service, and periodically returns to the home for less than ninety (90) days, they are not considered to be an adult household member and are not required to complete a background check. While in the home, they cannot have any unsupervised direct care responsibilities for any foster children in the home. Should they remain in the foster home for more than ninety (90) days, they will immediately be considered an adult household member and must complete a background check within fifteen (15) days from the date they became an adult household member. (7-1-25)
 - c. If the adult child continues to live in their parent's foster home or on the same property, they must complete a background check within fifteen (15) days of turning twenty-one (21). This requirement is not necessary if the adult child has completed a background check between the ages of eighteen (18) and twenty-one (21). (7-1-25)
03. **Background Check at Any Time.** The Department retains the authority to require a background check at any time on individuals who are residing in a foster home or on the foster parent's property. (7-1-25)
04. **Emergency Placement of Children.** An emergency occurs when a child enters or experiences an unplanned placement change in foster care. The Department may request that a criminal justice agency perform a Federal Interstate Identification Index name-based criminal history record check of each adult residing in the home. This refers to those limited instances when placing a child in the home of relatives or kin, as a result of a sudden unavailability of the child's parent or caretaker. (7-1-25)
 - a. All adult household members will submit fingerprints to the Department's Background Check Unit

within ten (10) calendar days and follow requirements outlined in IDAPA 16.05.06, ~~“Criminal History and Background Checks.”~~ The Department forwards the fingerprints to the State Central Record Repository for submission to the FBI within fifteen (15) calendar days from the date the name search was conducted. The Department's background check unit will positively identify the individual that is being considered to receive the child in an emergency situation as their fingerprints are submitted. (7-1-25)()

b. When placement of a child in a home is denied as a result of the Department review of the name-based criminal history record check of any adult household member, all adults must still comply with Subsection 202.054.a. of this rule and IDAPA 16.05.06, ~~“Criminal History and Background Checks.”~~ (7-1-25)()

c. The child will be removed from the home immediately if any adult household member fails to provide written permission to perform a federal criminal history record check, submit fingerprints, or any adult household member is denied a Department background check clearance. (7-1-25)

05. Exceptions to Background Checks. Background checks are optional for certain youth in foster care who reach the age of eighteen (18) but are less than twenty-one (21) years of age and continue to reside in the same licensed foster home. (7-1-25)

203. INITIAL AND ONGOING EVALUATION.

An applicant must participate in the process and tasks to complete an initial evaluation for foster care licensure. (7-1-25)

01. Applicant Participation. The applicant must do all the following: (7-1-25)

a. Cooperate with and allow the children's agency to determine compliance with these rules to conduct an initial foster home study; (7-1-25)

b. Inform the children's agency if the applicant is currently licensed or has been previously licensed as a foster parent or the applicant has been involved in the care and supervision of children or adults; (7-1-25)

c. All household members must disclose current mental health and/or substance abuse issues. (7-1-25)

d. All household members must provide information on their physical and mental health history, including any history of drug or alcohol abuse or treatment. (7-1-25)

e. Provide two (2) satisfactory references, one (1) of which may be from a person related to the applicant(s). An applicant will provide additional references upon the request of the children's agency. (7-1-25)

02. Disclosure of Information and Assurances. An applicant must provide the children's agency with the following or any additional information the children's agency deems necessary to complete the initial family home study: (7-1-25)

a. Names, including maiden or other names used, and ages of the applicant(s); (7-1-25)

b. Social Security Number; (7-1-25)

c. Education; (7-1-25)

d. Verification of marriages and divorces; (7-1-25)

e. Religious and cultural practices of the applicant including their willingness and ability to accommodate or provide care to a foster child of a different race, religion, or culture; (7-1-25)

f. Statement of income and financial resources and the family's management of these resources; (7-1-25)

- g.** Reasons for applying to be a foster parent; (7-1-25)
- h.** Report any prior arrest, investigation, or other official action regarding a sexual offense or impropriety. (7-1-25)
- i.** Provide and abide by the following written assurances: (7-1-25)

 - ~~**i.** Applicants will not use corporal or degrading punishment.~~ (7-1-25)
 - ii.** Applicants will not use any illegal substances, abuse alcohol by consuming it in excess amounts, or abuse legal prescription and/or nonprescription drugs by consuming them in excess amounts or using them contrary to as indicated. (7-1-25)
 - iii.** Applicants and their guests will not smoke in the foster family home, in any vehicle used to transport the child, or in the presence of the child in foster care. (7-1-25)
 - ~~**iv.** Applicants will adhere to the Department's reasonable and prudent parent standard.~~ (7-1-25)
- 03. Home Study.** The applicant must complete an agency home study, which is a written comprehensive family assessment to include the following elements: (7-1-25)

 - a.** At least one scheduled on-site visit to assess the home to ensure that it meets the standards set forth in these rules; (7-1-25)
 - b.** At least one scheduled in-home interview for each household member to observe family functioning and assess the family's capacity to meet the needs of a child or children in foster care; (7-1-25)
 - c.** The Department has discretion on whether to interview or observe each household member based on his or her age and development. (7-1-25)

(BREAK IN CONTINUITY OF SECTIONS)

239. TRANSPORTATION.

Applicants must ensure that the ~~family child(ren)~~ always has reliable, legal and safe transportation. Reliable transportation includes a properly maintained vehicle or access to reliable public transportation; ~~if a privately-owned vehicle owned by the applicant's family or friends is used to transport the child in foster care,~~ legal transportation includes having a valid driving license, insurance and registration; and safe transportation includes safety restraints as appropriate for the child. (7-1-25)()

240. – 241. (RESERVED)

242. CHILD PLACEMENT REQUIREMENTS.

A foster family may mutually accept the placement of children into the home within the terms of the foster home license and the children's agency placement agreement. The following provisions will be considered for determining placement: (7-1-25)

- 01. Determining Factors.** The number and the age group of children placed in a foster home will be determined by the following: (7-1-25)

 - a.** The accessibility, accommodations, and the space in the home; (7-1-25)
 - b.** The interest of the foster family; and (7-1-25)
 - c.** The experience, training, or skill of the foster family. (7-1-25)

02. Maximum Number of Children. Except as specified, the maximum number of children in care at any time, including the foster family's own children, or daycare children, will be limited to not more than six (6) children. (7-1-25)

03. Children Under Two Years Old. Except as specified in Subsection 242.04 of this rule, the maximum number of children under two (2) years old, including those of the foster family, will be limited to two (2) children or less. (7-1-25)

04. Special Circumstances Regarding Maximum Numbers of Children. The maximum number of children in care at any time may be ~~based on the children's agency assessment and at a minimum one (1) of the following~~ extended in order: (7-1-25)()

- a. To allow siblings to remain together; (7-1-25)
- b. To allow a child who has an established, meaningful relationship with the family to remain with the family; (7-1-25)
- c. To allow a family with special training or skills to provide care for a child who has a severe disability; or (7-1-25)
- d. To allow a parenting youth in foster care to remain with the child of the parenting youth. (7-1-25)

05. Continued Care. A foster child who reaches the age of eighteen (18) may continue in foster care placement until the age of twenty-~~one~~three (243) if the safety, health, and well-being of other foster children residing in the home is not jeopardized. (7-1-25)()

(BREAK IN CONTINUITY OF SECTIONS)

246. BEHAVIOR MANAGEMENT AND DISCIPLINE.

Methods of behavior management and discipline for children must be positive and consistent. These methods must be based on each child's needs, stage of development, and behavior. ~~Discipline is to promote self-control, self-esteem, and independence.~~ (7-1-25)()

- 01. Prohibitions.** The following types of punishment of a foster child are prohibited: (7-1-25)
- a. Physical force or any kind of punishment inflicted on the body, including spanking; (7-1-25)
 - b. Cruel and unusual physical exercise or forcing a child to take an uncomfortable position; (7-1-25)
 - c. Use of excessive physical labor with no benefit other than for punishment; (7-1-25)
 - d. Mechanical, medical, or chemical restraint; (7-1-25)
 - e. Locking a child in a room or area of the home; (7-1-25)
 - f. Denying necessary food, clothing, bedding, rest, toilet use, bathing facilities, or entrance to the foster home; (7-1-25)
 - g. Mental or emotional cruelty; (7-1-25)
 - h. Verbal abuse, ridicule, humiliation, profanity, threats, or other forms of degradation directed at a child or a child's family; (7-1-25)
 - i. Threats of removal from the foster home; (7-1-25)

j. Denial of visits or communication with a child's family unless authorized by a children's agency in its service plan for the child and family; and (7-1-25)

k. Denial of necessary educational, medical, counseling, or social services. (7-1-25)

02. Restraint. A foster parent who has received specific training in the use of child restraint may use reasonable restraint methods, approved by the children's agency, to prevent a child from harming themselves, other persons or property, or to allow a child to gain control of themselves. (7-1-25)

03. Authority. The authority for the discipline of a foster child must not be delegated by a foster parent to other members of the household. (7-1-25)

04. Agency Consultation. A foster parent must consult with the children's agency prior to using any behavior management or discipline technique that exceeds the scope of these rules. (7-1-25)

247. MEDICAL AND DENTAL CARE.

01. Health Care Services. A foster parent must follow and carry out the health or dental care plan for a child as directed by a medical professional. (7-1-25)

02. Child Injury and Illness. Follow the children's agency approved policies for medical care of a child ~~who is injured or ill.~~ (7-1-25)()

03. Dispensing of Medications. Provide prescription medication strictly as directed by a medical professional. ~~A foster parent must not discontinue or in any way change the medication provided to a child unless directed to do so by a medical professional.~~ (7-1-25)()

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.03 – DAYCARE LICENSING

DOCKET NO. 16-0603-2501 (CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 39-1107, 39-1111, 56-1003, 56-1004A, 56-1005(8), 56-1007, and 56-202, Idaho Code.

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

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. As such, the chapters of 16.06.12 and 16.06.03 are consolidated into what is proposed to be entitled IDAPA 16.06.03.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the July 2nd, 2025, Idaho Administrative Bulletin, [Vol. 25-7, pages 78 through 97](#).

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.

DATED this 31st day of July, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-1107, 39-1111, 56-1003, 56-1004A, 56-1005(8), 56-1007, and 56-202, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx	
Tuesday, July 15, 2025 1:00 PM (MT)	
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m6359ed9bafa6a855d48c6efbdde204c9	
Join by meeting number Meeting number (access code): 2824 295 1479 Meeting password: 8BTbtGWMS33 Meeting password when dialing from a phone or video system: 82828496	
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)	
Tuesday, July 29, 2025 3:00 PM (MT)	
Join from the meeting link https://idhw.webex.com/idhw/j.php?MTID=m966ad820ca5158be545aa683a2355941	
Join by meeting number Meeting number (access code): 2827 449 9066 Meeting password: 46Cb7tP5kpm Meeting password when dialing from a phone or video system: 46227875	
Join by phone +1-415-527-5035 United States Toll +1-303-498-7536 United States Toll (Denver)	

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:

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. As such, the chapters of 16.06.12 and 16.06.03 are consolidated into what is proposed to be entitled IDAPA 16.06.03.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted for 16.06.12 which has been consolidated into the greater chapter of 16.06.03. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking for 16.06.12 was published in the April 2nd, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 31 and 32](#).

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:

The provider manual is intended to include procedural guidance and clarifications that have been removed from formal rule but remain essential for consistent program administration. This includes topics not directly related to eligibility determinations, such as methods for averaging self-employment income, converting income to a monthly amount, and explaining good cause determinations etc. These operational details support accurate and uniform application of policy across the program.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at DHWRules@dhw.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 July 30th, 2025.

DATED this 28th day of May, 2025.

Italicized red text that is double underscored indicates amendments to the proposed text as adopted in the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0603-2501

16.06.03 – DAYCARE LICENSING AND IDAHO CHILD CARE PROGRAM (ICCP)

000. LEGAL AUTHORITY.

Sections [39-1107](#), [39-1111](#), [56-1003](#), [56-1004A](#), [56-1005\(8\)](#), and [56-1007](#), and [56-202](#), Idaho Code, ~~authorize the Department and the Board to adopt and enforce rules for licensing daycare centers, group daycare facilities, and family daycare homes.~~ [\(7-1-24\)\(\)](#)

001. INCORPORATION BY REFERENCE.

01. Occupational Safety and Health Act (OSHA) of 1970, as amended through November 23, 2021.
A copy of OSHA may be obtained at the Idaho Industrial Commission, 317 Main Street., P.O. Box 83720, Boise, Idaho, 83720-0041 or at <https://www.osha.gov/sites/default/files/publications/OSHA2001.pdf>. (7-1-24)()

02. ~~Crib Safety—Full Size Baby Cribs. Crib Safety.~~ Consumer Product Safety Commission, Compliance information for full size cribs can be found at <https://www.epsc.gov/Business-Manufacturing/Business-Education/FAQ?p=3019&tid%5b3028%5d=3028> 16 CFR Part 1219—Safety Standard For Full-Size Baby Cribs, June 28, 2011. This document is available here: <https://www.ecfr.gov/current/title-16/chapter-II/subchapter-B/part-1219>. (7-1-24)()

03. ~~Crib Safety—Non Full Size Baby Cribs. Crib Safety.~~ Consumer Product Safety Commission, Compliance information for non full size cribs can be found at <https://www.epsc.gov/Business-Manufacturing/Business-Education/FAQ?p=3019&tid%5b3029%5d=3029> 16 CFR Part 1220—Safety Standard For Non-Full-Size Baby Cribs, June 28, 2011. This document is available here: <https://www.ecfr.gov/current/title-16/chapter-II/subchapter-B/part-1220>. (7-1-24)()

04. 2025 Idaho Child Care Program Manual. The Idaho Child Care Program Manual can be found at: <https://healthandwelfare.idaho.gov/services-programs/children-families-older-adults/idaho-child-care-program>. ()

002. DEFINITIONS.

01. Earned Income. Income received by a person as wages, tips, or self-employment income before deductions for taxes or any other purpose. ()

02. Foster Care. The twenty-four (24) hour substitute care of children in the legal custody of the state of Idaho provided in a state licensed foster home by persons who may or may not be related to a child. Foster care is provided in lieu of parental care and is arranged through a private or public agency. ()

03. Foster Child. A child in the legal custody of the state of Idaho placed for twenty-four (24) hour substitute care by a private or public agency. ()

04. Good Cause. The conduct of a reasonably prudent person in the same or similar circumstances, unless otherwise defined in these rules. ()

05. Incapacitated Parent. A parent who is determined by a licensed practitioner of the healing arts to be unfit, incapable, or significantly limited in their ability to provide adequate care for their child or ward. ()

06. Legal Guardian. A court-appointed individual who acts as the primary caretaker of a child or minor. ()

07. Online Classes. Schooling completed primarily through online platforms regardless of occasional in-person classes. ()

08. Parent. A person responsible for a child because of birth, adoption, marriage, legal guardianship, foster care, or a person acting in loco parentis. ()

09. Plan of Correction. Procedures and activities developed between the Department and provider to bring a daycare facility into compliance. ()

10. Regularly on the Premises. Twelve (12) hours or more in any one (1) month, or daily during operating hours. ()

11. Relative Provider. Grandparent, great-grandparent, aunt, uncle, or adult sibling by blood or

current marriage who provides child care. ()

12. Special Needs. Any child with physical, mental, emotional, behavioral disabilities, or developmental delays identified on an Individual Education Plan (IEP) or an Individualized Family Service Plan (IFSP). ()

13. Unearned Income. Unearned income includes retirement, interest, child support, and any other income received from a source other than employment or self-employment. ()

0023. – 008. (RESERVED)

009. BACKGROUND CHECK REQUIREMENTS.

01. Compliance. Department enhanced background checks are required for individuals licensed under these rules and must comply with IDAPA 16.05.06, “Criminal History and Background Checks.” Applicants, providers, and individuals subject to criminal history checks must submit evidence of clearance from the Department before they are allowed to provide services or receive licensure, or certification to become an ICCP provider. After receiving a clearance, any new convictions must be reported to the Department once the provider learns of the conviction. A criminal history check may be requested for individuals providing child care at any time. (7-1-24)()

02. Background Check Requirements. Each owner, operator, or applicant seeking licensure for a daycare facility must submit evidence that the following individuals successfully completed and received a clearance for a Department enhanced background check, at least every five (5) years, under Sections 39-1105 and 39-1113, Idaho Code: (7-1-24)

- a. Owners, operators, and staff; (7-1-24)
- b. All other individuals thirteen (13) years old or older who have unsupervised direct contact with children; or (7-1-24)
- c. All other individuals thirteen (13) years old or older who are in the household or regularly on the premises; (7-1-24)

03. Family Daycare Homes. Under Section 39-1114, Idaho Code, any person providing daycare for four (4) or more children in a family daycare home is required to comply with Sections 39-1105 and 39-1113, Idaho Code. (7-1-24)

04. Background Check Frequency. The Department can require a background check at any time on any individual who is an owner, operator, staff, household member of a daycare facility, and all other individuals who are thirteen (13) years old or older who have unsupervised direct contact with children or who are regularly on the premises. (7-1-24)

05. Juvenile Justice Records. The enhanced background check for individuals under eighteen (18) years, must include a check of the juvenile justice records, as authorized by the minor and their parent or guardian. Records must be checked for each jurisdiction in which the individual has resided since becoming thirteen (13) through eighteen (18) years old. Each owner, operator, or applicant is responsible for requesting a check of the juvenile justice record, the associated costs of these records, and submitting them to the Department for review. A check of the juvenile justice records must include the following: (7-1-24)

- a. Juvenile justice records of adjudication of the magistrate division of the district court; (7-1-24)
- b. County probation services; and (7-1-24)
- c. Department records. (7-1-24)

06. Cost of Background Check and Juvenile Justice Records. Each individual who requests and

~~obtains a Department background check is responsible for the cost of the background check and check of juvenile justice records.~~ (7-1-24)

~~**07. Private Schools and Private Kindergartens.** Under Section 39-1105, Idaho Code, any person who owns, operates, or is employed by a private school for educational purposes for children four (4) through six (6) years old or a private kindergarten must comply with Sections 39-1105 and 39-1113, Idaho Code.~~ (7-1-24)

~~**08. Reporting Convictions.** Following completion of a background check and clearance, additional criminal convictions, and juvenile justice adjudications for disqualifying crimes under Section 39-1113, Idaho Code, must be self-disclosed by the individual to the owner or operator of a daycare facility. The owner or operator must report these additional convictions and adjudications to the Department within five (5) days of learning of the conviction or adjudication.~~ (7-1-24)

010. – 120. (RESERVED)

121. APPLICATION FOR DAYCARE LICENSE OR RENEWAL.

Any individual applying for licensure as a daycare facility must ~~be at least eighteen (18) years old, apply, and provide information required by the Department under this rule,~~ to include: (7-1-24)()

01. Completed Licensing Application. (7-1-24)

02. Licensing Fee. The ~~applicant nonrefundable fee~~ must ~~pay the appropriate licensing fee be paid~~ prior to the issuance of a daycare license. (7-1-24)()

03. Inspection Reports. The following ~~reports~~ must be submitted ~~to the Department~~ with the application that prove the facility or proposed facility meets: (7-1-24)()

a. Building code under IDAPA 24.39.30, ~~“Rules of Building Safety (Building Code Rules),”~~ where required; (7-1-24)()

b. Electrical code under IDAPA 24.39.10, ~~“Rules of the Idaho Electrical Board,”~~ where required; (7-1-24)()

c. Fire code under Section 41-253, Idaho Code, where required; and (7-1-24)

d. Local planning and zoning requirements. All daycare facilities must comply with applicable city and county ordinances. (7-1-24)

04. Proof of Insurance. The applicant must provide proof of current fire and liability insurance coverage for the daycare facility. (7-1-24)

~~**05. Background Clearance.** Evidence that the applicant and all individuals required to have a background check have received a clearance from the Department.~~ (7-1-24)

~~**065. Statement to Comply.** As part of the application, the a Applicants must thoroughly read, and review, these rules and agree that they are prepared to comply with all these provisions. Providers must also certify that they will not harm, shake, or abuse children, and that children in their care will not experience ensuring no maltreatment occurs under 45 CFR 98.41.~~ (7-1-24)()

~~**076. Statement Disclosing Revocation or Disciplinary Actions.** A written statement that discloses disclosing any revocation or other disciplinary action taken or in the process of being taken against the applicant as a daycare provider in any jurisdiction, or a statement from the applicant stating they have never been involved in any such action there has been none.~~ (7-1-24)()

087. Other Information as Requested. The applicant must provide ~~other any additional~~ information that may be requested by the Department for ~~the proper administration and rule~~ enforcement of these rules. (7-1-24)()

098. Health and Safety Inspection. The Department will order a health and safety inspection of the daycare facility once the application for licensure is complete, and the licensing fee has been paid. (7-1-24)()

1009. Additional Requirements for License Renewal. A daycare license must be renewed every two (2) years. ~~The daycare operator must submit to the Department by submitting~~ the renewal application, fee, and ~~all~~ required ~~documentation in this rule~~ documents at least forty-five (45) days ~~prior to the~~ before expiration of the current daycare license. (7-1-24)()

110. Relicense. ~~When a~~ A correctly completed renewal application ~~has been completed correctly,~~ keeps the existing license ~~will,~~ unless ~~officially~~ revoked, ~~remain in force~~ valid until the Department ~~has acted~~ acts on the application for renewal ~~it~~. (7-1-24)()

122. (RESERVED)

123. DISPOSITION OF APPLICATIONS.

The Department will ~~initiate action~~ act on ~~each~~ completed application within thirty (30) days ~~after receipt that addresses each requirement for the specific type of daycare license. Upon receipt of a completed application, the Department will~~ and review the ~~m~~ materials for compliance with ~~these rules~~ daycare license requirements. (7-1-24)()

01. Termination of Application Process. ~~Failure of the applicant to cooperate with the Department in during the application process may result in the lead to termination of the application process. Failure to cooperate means that the information requested is This includes not provided providing requested information within ninety (90) days, or not provided in the form requested by the Department, or both format.~~ (7-1-24)()

02. Denial of Application. If an application is denied, a signed letter will be sent ~~directly~~ to the applicant by registered or certified mail, ~~advising stating~~ the applicant of the denial and ~~stating~~ the basis ~~for such denial. An~~ The applicant ~~whose application has been denied~~ may not reapply until after one (1) year has elapsed from the date on the denial of application. This does not apply to licenses considered abandoned under Section 39-1104, Idaho Code. (7-1-24)()

03. Failure to Complete Application Process. ~~Failure of the applicant to complete the application process within six (6) months of the original date of application will result in a denial of the application being classified as abandoned.~~ (7-1-24)()

04. Denial of Licensure. If the Department determines the applicant is ~~not in compliance with these rules and further non-compliant and~~ determines not to issue a daycare license, ~~the Department it will, within thirty (30) days from the date the completed application is submitted, issue a letter of denial of licensure letter within thirty (30) days of the completed application stating the basis for the denial reason.~~ (7-1-24)()

05. Incomplete Application. The Department ~~is not required to take any action~~ acts on an application until the application ~~only when it~~ is complete. (7-1-24)()

06. Notification of License Renewal. The Department will notify the licensed daycare operator at least ninety (90) days ~~prior to expiration of~~ before the license expires. (7-1-24)()

124. – 149. (RESERVED)

150. RESTRICTIONS ON APPLICABILITY AND NONTRANSFER.

01. Issued License. A license applies only to the ~~designated~~ daycare facility ~~licensed by the Department, or the person and premises designated. Each license It is issued in the business name or individual name, and only to for the specified address identified on the application of the facility. A The license issued in the name of a daycare facility licensed by the Department applies is valid only to for the period and services specified detailed in the license it.~~ (7-1-24)()

02. Return of License. The operator must immediately return their license to the Department under any of the following circumstances: (7-1-24)

- a. Changes of ~~management~~ ownership or address; (7-1-24)()
- b. Upon suspension or revocation of the license; or (7-1-24)
- c. Upon voluntary discontinuation of service. (7-1-24)

03. Nontransferable. A license is nontransferable or assignable ~~from one (1) between~~ individuals, ~~to another, from one (1) business entity entities, or governmental unit to another, or from one (1) locations to another.~~ (7-1-24)()

04. Change in Ownership or Location. ~~When there is a change in~~ If ownership or location changes, the daycare facility must reapply for a license. ~~A license must be obtained~~ before starting operations. (7-1-24)()

151. – 199. (RESERVED)

200. STAFF AND OTHER RECORD REQUIREMENTS.

~~Each Daycare~~ owners or operators ~~of a daycare facility~~ must maintain a current list ~~covering the previous twelve-month period~~ of all staff and ~~other~~ individuals thirteen (13) years old or older ~~who have with~~ unsupervised direct contact with children, or are regularly on the premises. ~~The record over the past year and~~ must contain the following: (7-1-24)()

01. Legal Name. (7-1-24)
02. Proof of Age. (7-1-24)
03. Phone Number. (7-1-24)
04. Training Records. (7-1-24)
05. Verification of Background Check Clearance. (7-1-24)
06. Results of Juvenile Justice Records. (7-1-24)
07. Verification of Pediatric Rescue Breathing, Infant-Child CPR, and Pediatric First Aid Certification from a Certified Instructor. (7-1-24)
08. Times, Dates, and Records of Hours on the Premises Each Day. (7-1-24)

201. CHILD RECORD REQUIREMENTS.

~~Each Daycare~~ owners or operators ~~of a daycare facility~~ must maintain records for each child in attendance ~~covering for the previous twelve-months period. and The record~~ must contain the following: (7-1-24)()

01. Child's Full Name. (7-1-24)
02. Date of Birth. (7-1-24)
03. Parent or Guardian's Name, Address, and Contact Information. (7-1-24)
04. Emergency Contact Information. (7-1-24)
05. Child's Health Information. (7-1-24)
 - a. Immunization record or waiver of exemption form or statement; (7-1-24)

b. Any medical conditions or allergies that could affect the care of the child; and (7-1-24)

c. Medications the child is taking or may be allergic to. (7-1-24)

06. Times, Dates, and Record of Attendance Each Day. Sign-in/out records, electronic or manual, including the signature of a parent or guardian. (7-1-24)

202. – 359. (RESERVED)

360. FIRE SAFETY STANDARDS.

Each daycare facility must comply with the following. (7-1-24)

01. Inspections. Must be completed by the local fire official or designee. For a daycare located outside of the area of authority under Section 39-1109, Idaho Code, the Department can designate an approved inspector for daycare licensing purposes only. (7-1-24)

02. Daycare Fire Inspection Fees. Are payable to the local fire department or fire district official. (7-1-24)

03. Unobstructed Exits. Required exits must be located in such a way that an unobstructed path outside the building is provided to a public way or area of refuge. (7-1-24)

a. Exit doors must open from the inside without the use of a key or any special knowledge or effort. (7-1-24)

b. ~~There must be at least two (2) exits, located a distance apart of not less than~~ spaced at least one-half (1/2) the ~~diagonal dimension of the building's or portion used for daycare~~ diagonal dimension, but not to exceed over seventy-five (75) feet ~~apart are required~~. An exception may be made for the following: (7-1-24)()

i. The distance between exits may be extended to ninety (90) feet if the building is totally protected throughout with smoke detectors; or (7-1-24)

ii. The distance between exits may be increased to one hundred ten (110) feet if the building is equipped with an automatic fire sprinkler system. (7-1-24)

c. The ~~required dimensions of~~ exits must ~~not be less than be at least~~ thirty-two (32) inches ~~of clear exit width wide~~ and ~~not be less than~~ six (6) feet, eight (8) inches ~~in height tall~~. ~~An exception for sliding patio doors will be accepted can serve~~ as a ~~required~~ second exit in a family daycare home and group daycare facility only facilities. (7-1-24)()

d. ~~Each sleeping room exits must be provided with at least one (1) have an~~ emergency egress window ~~having at least a single net clear opening with a minimum clear opening size~~ of five point seven (5.7) square feet, ~~minimum a~~ height ~~of~~ twenty-four (24) inches, ~~minimum a~~ width ~~of~~ twenty (20) inches, and ~~maximum a~~ finished sill height not over forty-four (44) inches. (7-1-24)()

i. Approved egress windows from sleeping areas must be operable from the inside without the use of separate tools. (7-1-24)

ii. In lieu of egress windows, an approved exit door is acceptable. (7-1-24)

iii. An approved piece of furniture or platform, if anchored in place, may be approved to sit in front of a window if the sill height is over forty-four (44) inches. (7-1-24)

e. Where children are located on a story below the level of exit discharge (basement), there must be at least two (2) exits, one (1) of which must open directly to the outside. More than one (1) exit from the basement opening directly to the outside may be required, depending on the structure of the building, to ensure the safety of the

occupants. (7-1-24)

f. Where children are located on a story above the level of exit discharge, there must be two (2) exits, one (1) of which must open directly to the outside and comply with building codes. (7-1-24)

361. FACILITY CAPACITY AND DETERMINING OCCUPANT LOAD.

Occupant load is determined by the local fire official or designee. (7-1-24)

01. Area for Daycare Use Only. The local fire official or designee will only use those areas used for daycare purposes when determining the occupant load. (7-1-24)

02. Facilities with an Occupancy Load of Fifty or More. Must meet the requirements in Section 360 of these rules and this rule. (7-1-24)

a. Exit doors must swing in the direction of egress. (7-1-24)

b. Exit doors from rooms, if provided with a latch, must have panic hardware installed. (7-1-24)

03. Exit Signs. Must be installed at required exit doorways and wherever else necessary to clearly indicate the direction of egress. (7-1-24)

362. FIRE EXTINGUISHERS AND SAFETY REQUIREMENTS.

Each daycare facility must comply with the following fire extinguisher and safety requirements as applicable for size and type of facility. (7-1-24)

01. Portable Fire Extinguisher. There must be an approved portable fire extinguisher (minimum 2A-10BC) mounted securely in a visible location not to exceed five (5) feet from the floor to the top of the extinguisher and not more than seventy five (75) feet travel distance to an extinguisher and maintained properly. (7-1-24)

02. Kitchen Area. An approved fire extinguisher must be present, or a hood-type fire suppression system be installed in the kitchen area. (7-1-24)

03. Fire Extinguishers. Approved fire extinguishers must be maintained properly. (7-1-24)

04. Facilities Over Three Thousand Square Feet. Each daycare facility over three thousand (3,000) square feet is required to have additional fire extinguishers as approved by the local fire official or designee. (7-1-24)

05. Fire Alarm System. Each daycare facility with over fifty (50) children, must have an approved fire alarm system installed. (7-1-24)

06. Smoke Detectors. Must be installed and maintained in the following locations: (7-1-24)

a. On the ceiling, wall outside, or each separate sleeping area in the immediate vicinity of bedrooms; (7-1-24)

b. In each room used for sleeping purposes; and (7-1-24)

c. In each story within a facility including basements. (7-1-24)

d. If there is a basement, there must be a smoke detector installed in the basement having a stairway which opens from the basement into the facility. Such detector must be connected to a sounding device or other detector to provide an alarm that is audible in the sleeping area. (7-1-24)

07. Automatic Sprinkler Systems. Must be provided in all daycare facilities greater than twenty thousand (20,000) square feet in area or when the number of children under the age of eighteen (18) months exceeds one hundred (100). (7-1-24)

363. FIRE SAFETY AND EVACUATION PLANS.

Each daycare facility must have an approved fire safety and evacuation plan prepared that includes the following: (7-1-24)

- 01. Evacuation.** Procedures and policies for accounting for staff and children after an evacuation is completed. (7-1-24)
- 02. Evacuation Plan and Assembly Point for Children and Staff.** (7-1-24)
- 03. Locations of Facility Exits.** (7-1-24)
- 04. Evacuation Routes.** (7-1-24)
- 05. Location of Fire Alarms.** (7-1-24)
- 06. Location of Fire Extinguishers.** (7-1-24)
- 07. Annual Review.** Fire safety and evacuation plans must be reviewed or updated annually and available in the facility for reference and review. (7-1-24)
- 08. Fire and Emergency Evacuation Drills.** Must be conducted on a routine schedule at least two (2) times each year and all staff and children must participate. (7-1-24)

364. – 379. (RESERVED)

380. HEALTH STANDARDS.

Each daycare facility licensed by the Department, must comply with the following. Health inspections must be conducted annually by a qualified inspector designated by the Department and will be unannounced. (7-1-24)

01. Food. Must be from an approved source under IDAPA 16.02.19, "~~Idaho Food Code.~~" Food must not be served past expiration or "use by" date. (7-1-24)()

~~**02. Food Preparation.** Food for use in daycare facilities must be prepared and served in a sanitary manner with sanitized utensils and on surfaces that have been cleaned, rinsed, and sanitized prior to use to prevent cross-contamination.~~ (7-1-24)

a. Frozen food must be thawed in the refrigerator, under cold running water, or as part of the cooking process and cooked to proper temperatures under IDAPA 16.02.19, "~~Idaho Food Code.~~" (7-1-24)()

b. Individuals preparing food must use proper hand-washing techniques, minimize bare hand contact with food, and wear clean clothes. (7-1-24)

~~**032. Food Temperatures.** Potentially hazardous foods must be kept refrigerated at forty-one degrees Fahrenheit (41°F) or below, held hot at one hundred thirty-five degrees Fahrenheit (135°F) or more, and reheated or cooled at safe temperatures under IDAPA 16.02.19, "~~Idaho Food Code.~~" Refrigerators must be equipped with an accurate thermometer.~~ (7-1-24)()

~~**043. Food Storage.** All food that is served in daycare facilities must be stored in such a manner that protects it from potential contamination.~~ There must be no evidence of pests present in the daycare facility. (7-1-24)()

~~**054. Food Contact Surfaces.** Must be kept clean and sanitized, including counters, serving tables, high chair trays, and cutting boards.~~ (7-1-24)

~~**065. Dishwashing Sanitizing.** Dishes, glasses, utensils, silverware, and all other objects used for food preparation and eating must be sanitized using appropriate sanitizing procedures.~~ (7-1-24)

076. Utensil Storage. Clean utensils must be stored on clean shelves or drawers and not subject to recontamination, and sharp knives and other sharp objects be kept out of reach of children. (7-1-24)

087. Garbage. Must be kept covered or inaccessible to children. (7-1-24)

~~09. **Hand Washing.** Children and facility staff must be provided with individual or disposable towels for hand drying, and the hand washing area be equipped with soap and warm and cold running water.~~ (7-1-24)

108. Diaper Changing. Must be conducted in such a manner as to prevent the spread of communicable diseases, be separate from food preparation and serving areas, and have easy access to a hand washing sink. (7-1-24)()

~~11. **Sleeping Areas.** Children sleeping at the facility must have separate cots, mats, or beds and blankets.~~ (7-1-24)

120. Safe Sleep. Providers must place newborn infants up to twelve (12) months old in a safe sleep environment. Safe sleep practices include alone, on their backs, and in a Consumer Product Safety Commission (CPSC) certified sleep space. (7-1-24)

130. Restrooms, Water Supply, and Sewage. All daycare facilities must have restrooms. (7-1-24)

a. Each facility must have at least one (1) flushable toilet and one (1) hand washing sink with warm and cold water per restroom. (7-1-24)

b. Plumbing and bathroom fixtures must be in good condition. (7-1-24)

c. All daycare facilities and homes must comply with IDAPA 24.39.30, "Rules of Building Safety (Building Code Rules)." (7-1-24)()

141. Water Supply. The facility's water supply must meet one (1) of the following requirements: (7-1-24)

a. Be from a public water system that is maintained under IDAPA 58.01.08, "Idaho Rules for Public Drinking Water Systems," at the time of initial or renewal application; or (7-1-24)()

b. Be from a private source, such as well or spring, be tested annually for bacteria and nitrate, and be approved by the Department. (7-1-24)

c. Water used for consumption at a daycare facility is from an acceptable source. Temporary use of bottled water or boiled water may be allowed for a period specified by the Department. (7-1-24)

152. Sewage Disposal. Facility sewage must be disposed of through a public system, or in the absence of a public system, in a manner approved by the local health authority under IDAPA 58.01.03 "Individual/Subsurface Sewage Disposal Rules." (7-1-24)()

163. Alcohol and Illegal Drugs. Must not be used by providers, owners, operators, staff, volunteers, children, or visitors at daycare facilities, in the presence of children during hours of operation, or in vehicles while transporting children. (7-1-24)

a. Any individual under the influence of alcohol or drugs is not permitted at or in the daycare facility. (7-1-24)

~~b. **Illegal drugs are prohibited by law and therefore are not allowed on the premises of any licensed daycare facility at any time.**~~ (7-1-24)

174. Smoke-Free Environment. Children must be afforded a smoke-free environment during all daycare hours, whether indoors or outdoors. While children are in care, the operator and all staff must ensure that no

smoking or other tobacco use occurs within the facility, in outdoor areas, or in vehicles when children are present. (7-1-24)

~~185.~~ **Transportation.** ~~Provider that transports a child(ren) will possess a valid driver's license, be insured under Idaho Law, and abide by all traffic laws including the requirement that all children are in proper safety restraints while being transported under Section 49-672, Idaho Code, and Section 49-673, Idaho Code.~~ Vehicles used to transport children will be properly maintained and in good working condition. (7-1-24)()

~~196.~~ **Disaster and Emergency Planning.** Providers must have documented plans for emergencies resulting from a natural disaster, or human-caused event that include: (7-1-24)

a. Procedures for evacuation, relocation, shelter-in-place, lock-down, communication and reunification with families, continuity of operations, and accommodation of infants and toddlers and children with disabilities or chronic medical conditions. (7-1-24)

b. Procedures for staff and volunteer emergency preparedness training and practice drills. (7-1-24)

c. Guidelines for the continuation of daycare services in the period following the emergency or disaster. (7-1-24)

d. Procedures for the prevention of and response to emergencies due to food and allergic reactions. (7-1-24)

~~2017.~~ **Medication.** No person can administer any medication to a child without it first being authorized by a parent or caretaker. All medications, refrigerated or unrefrigerated, must be in a locked box or otherwise in inaccessible to children. (7-1-24)

~~218.~~ **Adequate Heat, Light, and Ventilation.** A daycare facility must have adequate heat, light and ventilation. Windows and doors must be screened if used for ventilation. (7-1-24)

~~22.~~ **Immunizations.** ~~Daycare operators must comply with requirements under IDAPA 16.02.11, "Immunization Requirements for Licensed Daycare Facility Attendees."~~ (7-1-24)

381. MISCELLANEOUS SAFETY REQUIREMENTS.

Each daycare facility licensed by the Department must comply with the following: (7-1-24)

01. Telephone. An operable telephone ~~or cell phone~~ must always be available in the facility with the following conditions: (7-1-24)()

a. The telephone number used must be made available to parents and guardians. (7-1-24)

b. Emergency phone numbers ~~to include~~ including 911, an adult ~~emergency~~ substitute operator, and the ~~facility~~ address, and phone number ~~of the facility~~ must be posted by the telephone or ~~in a location that is~~ easily and always visible ~~at all times~~. (7-1-24)()

02. Heat-Producing Equipment. A furnace, fireplace, wood-burning stove, water heater, and other flame or heat-producing equipment must be installed and maintained as recommended by the manufacturer and protected on all surfaces by screens or other means. (7-1-24)

03. Portable Heating Devices. Must be limited and approved for use and location by the Fire Inspector prior to use within a facility and will not be used during sleeping hours. (7-1-24)

04. Storage of Weapons, Firearms, and Ammunition. Firearms or other weapons stored at a daycare facility must be kept in a locked cabinet, gun safe, or other container that is inaccessible to children, while children are in attendance. Keys to these containers must also be inaccessible to children. (7-1-24)

a. Ammunition must be stored in a locked container separate from firearms. (7-1-24)

b. Matches, lighters, and any other means of starting fires must be kept away from and out of the reach of children. (7-1-24)

c. Other weapons that could cause harm must be stored out of reach of children. (7-1-24)

05. Animals and Pets. Any pet or animal present at the facility, indoors or outdoors, must be in good health, show no evidence of carrying disease, and be a friendly companion of the children. The operator must maintain the animal's vaccinations and vaccination records which will be made available to the Department upon request. (7-1-24)

06. Hazardous Materials. Cleaning materials, flammable liquids, detergents, aerosol cans, pesticides, and other poisonous and toxic materials must be kept in their original containers and in a place inaccessible to children. They must be used in such a way that will not contaminate play surfaces, food, food preparation areas, or constitute a hazard to the children. Biocontaminants must be disposed of appropriately. (7-1-24)

382. – 399. (RESERVED)

400. BUILDINGS, GROUNDS, FURNISHINGS, AND EQUIPMENT.
Each daycare facility licensed by the Department must comply with the following: (7-1-24)

01. Appliances and Electrical Cords. All appliances, lamp cords, exposed light sockets, and electrical outlets will be protected to prevent electrocution. (7-1-24)

02. Balconies and Stairways. Balconies and stairways accessible to children will have substantial railings as required by IDAPA 24.39.30, "~~Rules of Building Safety (Building Code Rules)~~". (7-1-24)()

03. Stairway Protection. Where an operator cares for children less than three (3) years old, stairways will be protected to prevent child access to stairs. (7-1-24)

04. Hazardous Area Restrictions. Based on the age and functioning level of children in care and the type of hazard and the area surrounding the hazard, the area will be restricted to prevent easy access to the hazard. (7-1-24)

05. Fueled Equipment. Fueled equipment including motorcycles, mopeds, lawncare equipment, and portable cooking equipment. This equipment will not be stored or repaired in areas where children are present. (7-1-24)

~~**06. Water Hazards.** Above and below ground pools, hot tubs, ponds, and other bodies of water that are on the daycare facility premises must provide the following safeguards:~~ (7-1-24)

~~**a.** The area surrounding the body of water must be fenced and locked in a manner that prevents access by children and meets the following~~ (7-1-24)

~~i. The fence will be at least four (4) feet high with no vertical opening more than four (4) inches wide and designed so that a young child cannot climb or squeeze under or through the fence. The fence will surround all sides of the pool and have a self-closing gate that has a self-latching mechanism in proper working order that is out of the reach of young children.~~ (7-1-24)

~~ii. If the house forms one (1) side of the barrier for the pool, all doors that provide unrestricted access to the pool will have alarms that produce an audible sound when the door is opened.~~ (7-1-24)

~~**b.** Furniture or other large objects will not be left near the fence in a manner that would enable a child to climb on the furniture or other large object and gain access to the pool. If the area surrounding a pool, hot tub, pond, or other body of water is not fenced and locked, there will be a secured protective covering that prevents access by a child.~~ (7-1-24)

- ~~c. Wading pools and buckets will be empty when not in use. (7-1-24)~~
- ~~d. Children will be under direct supervision of adult staff who are certified in pediatric CPR and pediatric first aid while using a bathtub, pool, hot tub, pond, or other body of water. (7-1-24)~~
- ~~e. A minimum of a four (4) foot high fence that prevents access from the daycare facility premises if the daycare premises are adjacent to a body of water. (7-1-24)~~

076. Indoor Play Areas and Toys. The indoor play areas will be clean, have age-appropriate toys, and be free from accumulation of dirt, rubbish, or other health hazards. (7-1-24)

087. Outdoor Play Areas and Toys. Any outdoor play area must be maintained free from hazards such as wells, machinery, and animal waste. (7-1-24)

a. If any part of the play area is adjacent to a busy roadway, drainage or irrigation ditch, stream, large holes, or other hazardous areas, the play area will be enclosed with a fence in good repair that is at least four (4) feet high without any holes or spaces greater than four (4) inches in diameter. (7-1-24)

b. Outdoor equipment, such as climbing apparatus, slides, and swings will be anchored firmly and placed in a safe location and according to the manufacturer's instructions. (7-1-24)

c. Outdoor play areas will be designed so that all parts are always visible and easily supervised by staff. (7-1-24)

d. Toys, play equipment, and any other equipment used by the children will be of substantial construction and free from rough edges and sharp corners. Unguarded ladders on slides will be kept in good repair and well-maintained. (7-1-24)

e. Toys and objects with a diameter of less than one (1) inch (two point five (2.5) centimeters), objects with removable parts that have a diameter of less than one (1) inch (two point five (2.5) centimeters), plastic bags, styrofoam objects, and balloons will not be accessible to children ages three (3) and under, or children who are known to place such objects in their mouths. (7-1-24)

401. – 419. (RESERVED)

420. CONTINUED COMPLIANCE, REPORTING CHANGES, AND CRITICAL INCIDENTS.

Each daycare owner or operator must always comply with the fire, safety, and health requirements under these rules and the following: (7-1-24)

01. Department Access. The ~~owner, operator, or staff of a daycare facility~~ Department must be allowed ~~the Department~~ access to the premises and records for reinspection ~~at any time~~ anytime during the licensing period. (7-1-24)()

02. Posting Information. A daycare must post the Department's contact information and the statewide number to file daycare complaints. (7-1-24)

03. Reporting Changes. The ~~owner, operator, or staff of a daycare facility~~ notifies the Department ~~that affect the terms of~~ must be notified of any changes ~~that affect the terms of~~ affecting licensure or ~~could affect~~ the health, well-being, or safety of children. (7-1-24)()

04. Critical Incidents. A daycare operator must report ~~any of~~ the following to the Department within twenty-four (24) hours: (7-1-24)()

a. Any injury that requires hospitalization of a child. (7-1-24)

b. Death or near death of a child in care. (7-1-24)

c. When a child is missing from a daycare facility. (7-1-24)

d. Any arrests, citations, withheld judgments, or criminal convictions of disqualifying crimes under Section 39-1113, Idaho Code, of an operator or any individual regularly on the premises ~~of the facility and provide with documentation that proving they individual is do~~ not working with children or ~~is are~~ not ~~on the premises present~~. (7-1-24)()

421. ICCP ELIGIBILITY FOR BENEFITS.

The following requirements must be met to be considered for ICCP: ()

01. Application. Applicants must complete and sign an application. Verifications are required within thirty (30) days, otherwise a new application is required; ()

02. Residency. Applicants must live within the state of Idaho with no immediate intention of leaving; ()

03. Asset Cap. An applicant's family assets must not exceed one million dollars (\$1,000,000); ()

04. Cooperation with Child Support Services. An applicant must cooperate with establishing paternity and obtaining child support if applicable, unless good cause is granted; and ()

05. Eligible Child. A family may receive child care benefits so long as the child(ren) is: ()

a. A citizen or living lawfully in the United States; and ()

b. Be under thirteen (13) years of age unless the child is physically or mentally unable to self-care and is verified by a licensed mental health professional, or licensed medical professional, or is under court supervision, in which case benefits may continue until the month of the child's nineteenth (19th) birthday. ()

422. INCOME LIMITS.

A family must have income that does not exceed the following published Federal Poverty Guidelines (FPG); ()

01. Income at Application. One hundred thirty percent (130%) of FPG for a family of the same size. ()

02. Income During Eligibility Period. Eighty-five percent (85%) of the State Median Income (SMI) for a family of the same size. ()

03. Income at Redetermination. If income exceeds one hundred forty-five percent (145%) of FPG for a family of the same size. The family may be eligible to receive a graduated phase out of child care assistance. ()

423. COUNTABLE INCOME.

All gross earned and unearned income is counted in determining eligibility and the child care benefit amount, unless specifically excluded under these rules. ()

424. EXCLUDED INCOME.

The following sources of income are not counted: ()

01. Earned Income of a Dependent Child. Income earned by a dependent child under age eighteen (18) is not counted, unless the child is a parent who is seeking or receiving child care benefits. ()

02. Income Received for Person Not Residing With the Family. ()

03. Educational Funds. Including grants, scholarships, AmeriCorps Education Award, and federal and state work-study income. ()

04. Assistance. Assistance to meet a specific need from other organizations and agencies. ()

- 05. Lump Sum Income.** Non-recurring lump sum income is excluded. ()
- 06. Loans.** Funds received that are to be repaid. ()
- 07. TANF and AABD Benefits.** ()
- 08. Foster Care Payments and Foster Parents' Income.** Income of licensed foster parents are excluded when determining eligibility for a foster child. When determining eligibility for the foster parent's child(ren), income is counted. ()
- 09. AmeriCorps/VISTA Volunteers.** Living allowances, wages and stipends paid under 42 U.C.S. 5044, P.L. 93-113, Title IV, Section 404(g). ()
- 10. Income Tax Refunds and Earned Income Tax Credits.** ()
- 11. Travel Reimbursements.** Work-related travel funds from employers. ()
- 12. Tribal Income.** Income received from a tribe for any purpose other than direct wages. ()
- 13. Temporary Census Income.** Census Bureau temporary pay related to U.S. Census activities are excluded for up to six (6) months during the regular ten-year U.S. Census. ()
- 14. Workforce Investment Act (WIA) Benefits or Workforce Innovation and Opportunity Act (WIOA) Benefits.** ()
- 425. INCOME DEDUCTIONS.**
Court-ordered child support payments made by a parent receiving child care benefits are deducted from income eligibility, with verification of actual payment and legal obligation. ()
- 426. CHANGE REPORTING REQUIREMENTS.**
A family must report the following permanent changes by the tenth of the month following in which the change occurred. The Department will take action the month in which the change was reported. ()
- 01. Permanent Address.** ()
- 02. Qualifying Activity.** ()
- 03. Household Composition.** ()
- 04. Income.** When the household's total gross income for a family of the same size exceeds any of the following: ()
- a. One hundred and thirty percent (130%) of the Federal Poverty Guidelines (FPG);** ()
- b. Eighty-five percent (85%) of the State Median Income (SMI); or** ()
- c. The graduated phase-out income limit.** ()
- 05. Change in Child Care Provider or Child Permanently Stops Attending.** ()
- 427. REDETERMINATION OF ELIGIBILITY FOR CHILD CARE BENEFITS.**
- 01. Redetermination.** The Department will redetermine eligibility for child care benefits at least every twelve (12) months. ()
- 02. Graduate Phase Out.** At redetermination, if a household's income exceeds one hundred forty-five

percent (145%) of FPG for a family of the same size, eligible children may receive a graduated phase out benefit that is limited to twelve (12) months following the completion of redetermination. ()

428. FAMILY COMPOSITION.

A family is a group of individuals living in a common residence, whose combined income is considered in determining eligibility and the child care benefit amount. No individual may be considered a member of more than one (1) family in the same month. The following individuals are included in determining the family composition: ()

01. Married Parents. Married parents, includes biological, adoptive, step-parent, guardian, and foster parent. ()

02. Unmarried Parents. Unmarried parents who have a child in common living with them. ()

03. Dependents. Individuals who are dependents of a parent, guardian, or caretaker relative. ()

04. Minor Parent. A minor parent under the age of eighteen (18) and child are considered a separate family when they apply for child care benefits, even if they live with other relatives. ()

05. A Legal Guardian. An individual who is eligible to apply for child care benefits, and the child's natural or adoptive parents are not living in the home. ()

06. Citizenship or Alien Status Requirement. Family members who are not citizens or living lawfully in the United States will not be counted in the family size. Their income will be counted when determining the household's income. ()

07. Child Custody. A child may alternate between parents' homes; but not be a member of both. If not agreed, primary custody determines household for child care benefits, based on where the child stays fifty-one (51%) or more nights. If only one parent applies for benefits, the child may be in their household without primary custody. ()

429. INCAPACITATED PARENT.

An incapacitated parent, in a two (2) parent family, is not required to have any qualifying activities, as long as the other parent is participating in qualifying activities. A single parent family in which the parent is incapacitated is not eligible for ICCP. A parent with a disability does not automatically qualify as an incapacitated parent. ()

430. QUALIFYING ACTIVITIES FOR CHILD CARE BENEFITS.

Each parent included in the household must need child care because they are engaged in one (1) qualifying activities listed below. ()

01. Employment. The parent is currently employed in a job paying wage or salary at federal minimum wage, including work paid by commission or in-kind compensation. ()

02. Self-Employment. The parent is currently self-employed in a business that is a sole proprietorship. Restrictions apply as follows: ()

a. Actual activity hours are used for the first twelve (12) months. ()

b. At month thirteen (13), activity hours are limited by dividing self-employment income by the federal minimum wage, taking the lesser of the calculated activity hours or actual activity hours. ()

03. Training or Education. The parent is attending an accredited education or training program that must prepare the trainee for employment. Restrictions apply as follows: ()

a. On-line classes and post baccalaureate classes cannot be counted. ()

b. More than forty-eight (48) months of post-secondary education has been used as a qualifying ()

activity. ()

04. Preventive Services. The parent is receiving preventive services that aim to prevent out-of-home placement by engaging in activities to reduce the need for protective intervention. Verification of continued need will be done every three (3) months. ()

05. Personal Responsibility Contract (PRC) or Other Negotiated Agreement. The parent is completing Personal Responsibility Contract (PRC) or other self-sufficiency activities negotiated between the Department and the parent. ()

431. PROJECTING QUALIFYING ACTIVITY HOURS.

Activity hours are projected for each month to determine if payment is made on a full-time {thirty-two (32)} hours or more per week) or part-time {sixteen (16) to thirty-one (31)} hours per week) basis. Past activity hours may be used to project future activity hours if the employer and number of hours worked are the same and are expected to remain the same throughout the certification period. Hours for each qualifying activity must be projected individually and converted to a monthly amount. ()

432. CESSATION OF QUALIFYING ACTIVITIES.

An eligible family who ceases its qualifying activity, may continue to receive assistance for up to three (3) months. ()

433. IN-HOME CARE.

Parents must request and obtain approval for in-home child care from the Department and have qualified activities outside their home. Approval is limited to the following circumstances: ()

01. Availability. Child care is needed during any period when out-of-home care is not available. ()

02. Residency. The family lives in an area where out-of-home care is not available. ()

03. Illness or Disability. A child has a verified illness or disability and would place the child or other children in an out-of-home facility at risk. ()

434. ALLOWABLE CHILD CARE COSTS.

Care provided to an eligible child by an eligible child care provider is payable subject to the following conditions: ()

01. Parent's Qualifying Activities. The need for childcare must be reasonably related to the parent's qualifying activities. ()

02. One-Time Registration Fees. One-time fees for registering a child in a child care facility are payable above the local market rate, if the fee is charged to all who enroll in the facility with reimbursement capped at one hundred fifty dollars (\$150) and must be usual and customary rates charged to all families. Registration fees are separate from local market rates. ()

435. NON-ALLOWABLE CHILD CARE COSTS.

Care provided to an eligible child is not payable under the following conditions: ()

01. Family Member or Guardian Providing Child Care. A parent, step-parent, or guardian providing child care to their own child or ward. ()

02. Provider Living at Same Address as Child. If the provider lives at the same address as the child who in-home child care is provided to. ()

03. School Tuition, Academic Credit, or Tutoring. ()

a. Any services provided to such students during the regular school day, including kindergarten;

()

b. Any services for which such students receive academic credit toward graduation; or ()

c. Any instructional services which supplant or duplicate the academic program of any public or private school. ()

436. AMOUNT OF PAYMENT.

Child care payments will be based on the following: ()

01. Payment Rate. Payment will be based on the provider's usual and customary rates or the Local Market Rate (LMR), whichever is lower. ()

a. Local market rates are the maximum monthly amounts ICCP pays for specific child care types in designated regions determined by the Department through surveys every three years. The survey will use the age of child, the type of child care, and the designated area where the provider does business. ()

b. Payment rates will be determined by the location of the child care facility. ()

c. If the child care facility is not in Idaho, the local market rate will be the rate where the family live. ()

02. Usual and Customary Rates. Rates charged by the child care provider must not exceed the usual and customary rates charged for child care to persons not entitled to receive benefits under ICCP. ()

03. In-Home Care. Parents are responsible to pay persons providing care in the child's home the minimum wage, as required by the Fair Labor Standards Act (29 U.S.C. 206a) and other applicable state and federal requirements. ()

04. Payments. Payments will be issued directly to eligible providers. ()

437. COPAYMENTS.

Eligible families, except TANF families participating in non-employment TANF activities and guardians of foster children, must pay part of their child care costs. ()

01. Provider Responsibility. Providers are responsible for ensuring families pay the determined child care costs and must not waive these costs. ()

02. Family Payment. Family income and activity for the month of the child care will determine the family costs. The Department's payment equals the lower of allowable local market rate or billed costs, minus the co-payment. ()

438. STUDENT CO-PAYMENT REQUIREMENTS.

01. Post-Secondary Student. ()

a. A student working less than ten (10) hours per week will be required to pay a co-payment. ()

b. A student working ten (10) hours or more per week will have a co-payment based on family income. ()

02. High School Student. A student who is in high school, or who is taking GED courses will have a co-payment based on family income. ()

439. INTERIM CHILD CARE PAYMENT.

If child care arrangements would otherwise be lost, child care may be paid when a child temporarily stops attending child care for no longer than (1) calendar month and plans to return. ()

440. FUNDING RESTRICTIONS.

If a funding shortfall is projected, the Department may take action to ensure that ICCP operates within its appropriation. ()

441. REFUSAL TO ENTER INTO AN AGREEMENT.

The Department may refuse to enter into a provider agreement for the following reasons: ()

01. Convicted of a Felony. The provider has been convicted of a felony or is under investigation for the commission of a felony. ()

02. Committed an Offense or Act Not in Best Interest of Child Care Participants. The provider has committed an offense or act which the Department determines is inconsistent with the best interests of ICCP participants. ()

03. Failed to Repay. The provider has failed to repay the Department monies which had been previously determined to have been owed to the Department. ()

04. Investigation Pending. The provider has a pending investigation for program fraud or abuse. ()

05. Terminated Provider Agreement. The provider was the managing employee, officer, owner, or spouse, partner, or relative of an owner of an entity, whose provider agreement was terminated under Section 750 of these rules. ()

06. Excluded Individuals. The provider has a current exclusion from participation in federal programs by the Office of Inspector General List of Excluded Individuals and Entities. ()

442. PROVIDER NOTIFICATION.

When the Department determines actions defined in these rules are appropriate, it will send written notice of the decision to the provider or person. The notice will state the basis for the action, the length of the action, the effect of the action on that person's ability to provide services under state and federal programs, and the person's appeal rights. ()

~~421~~**43.** – 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.12 – IDAHO CHILD CARE PROGRAM (ICCP)

DOCKET NO. 16-0612-2501 (ZBR CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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.

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. As such, the chapters of 16.06.12 and 16.06.03 are consolidated into what is proposed to be entitled IDAPA 16.06.03. 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 July 2nd, 2025, Idaho Administrative Bulletin, [Vol. 25-7, page 98](#).

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.

DATED this 31st day of July, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 16, 2025.

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:

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. As such, the chapters of 16.06.12 and 16.06.03 are consolidated into what is proposed to be entitled IDAPA 16.06.03.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted for 16.06.12 which has been proposed to be consolidated into the greater chapter of 16.06.03. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking for 16.06.12 was published in the April 2, 2025 Idaho Administrative Bulletin, [Volume 25-4, pages 31 and 32](#).

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 Jared Larsen at DHWRules@dhw.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 July 23rd, 2025.

DATED this 28th day of May, 2025.

IDAPA 16.06.12 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE
16.06.13 – EMERGENCY ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0613-2501 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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.

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. As such, the chapters of 16.03.08, 16.06.13, and 16.04.14 are consolidated into what is proposed to be entitled IDAPA 16.03.08. 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 July 2nd, 2025, Idaho Administrative Bulletin, [Vol. 25-7, page 99](#).

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.

DATED this 31st day of July, 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

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

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

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 16, 2025.

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:

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 rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language. As such, the chapters of 16.03.08, 16.06.13, and 16.04.14 are consolidated into what is proposed to be entitled IDAPA 16.03.08.

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

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

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted for 16.03.08 which is being proposed to be consolidated with 16.04.14 and 16.06.13. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking for 16.03.08 was published in the April 2, 2025, Idaho Administrative Bulletin, [Volume 25-4, pages 21 and 22](#).

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 Jared Larsen at DHWRules@dhw.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 July 23, 2025.

DATED this 28th day of May, 2025.

IDAPA 16.06.13 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.05.01 – RULES OF THE BOARD OF DRINKING WATER AND WASTEWATER PROFESSIONALS

DOCKET NO. 24-0501-2501 (FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis \(CBA\)](#)

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 [54-2406\(1\)](#), Idaho Code.

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

This pending rule would: (1) update the calculation of continuing education and limit the number of managerial units required, (2) reduce regulatory burdens by eliminating the responsible charge requirements and decrease system classifications, (3) clarify completions for apprenticeship programs, (4) streamline the process for acquiring a higher level of license, and (5) address the Board's cash balances by increasing fees.

Changes have been made to the proposed rule text in order to clarify the number of CEU hours and college credits needed when substituting for experience hours, reducing licensing and renewal fee increases, and adding minor technical corrections to the rule chapter.

The text of the pending rule has been amended in accordance with Section [67-5227](#), Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 1, 2025, Idaho Administrative Bulletin, [Vol. 25-10, pages 307-312](#).

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:

As authorized in Sections [54-2406\(1\)](#) and [54-2407\(1\)](#), Idaho Code, the fees in this rulemaking are increased to comply with Section [67-2608\(3\)](#), Idaho Code, requiring that low fund balances be rectified.

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 on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ryan Bernard, Legislative and Regulatory Affairs Chief, at (775) 870-7926.

DATED this 5th day of December, 2025.

Ryan Bernard
Legislative and Regulatory Affairs Chief
PO Box 83720
Boise, ID 83720-0063
Phone: (775) 870-7926
Email: ryan.bernard@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to [Section 54-2406\(1\)](#), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2025.

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

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

These proposed rules changes would: (1) update the calculation of continuing education and limit the number of managerial units required, (2) reduce regulatory burdens by eliminating the responsible charge requirements and decrease system classifications, (3) clarify completions for apprenticeship programs, (4) streamline the process for acquiring a higher level of license, and (5) address the Board's cash balances by increasing fees.

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

Fees are authorized by [Sections 54-2406\(1\)](#) and [54-2407\(1\)](#), Idaho Code. Fee increase required to comply with [Section 67-2608\(3\)](#), Idaho Code.

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\(1\)](#), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the August 6, 2025 Idaho Administrative Bulletin, [Vol. 25-8, Pages 165-166](#).

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) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 13th day of August, 2025.

THE FOLLOWING IS THE TEXT OF FEE DOCKET NO. 24-0501-2501

Italicized red text that is double underscored indicates amendments to the proposed text as adopted in the pending rule.

24.05.01 – RULES OF THE BOARD OF DRINKING WATER AND WASTEWATER PROFESSIONALS

002. DEFINITIONS.

01. Very Small Public Drinking Water System. A community or non-transient non-community public drinking water system that serves five hundred (500) persons or ~~less~~ fewer and has no treatment other than disinfection or has only treatment which does not require any chemical treatment, process adjustment, backwashing or media regeneration by an operator (e.g. calcium carbonate filters, granular activated carbon filters, cartridge filters, ion exchangers). (7-1-24)()

02. Very Small Public Wastewater System. A public wastewater system that serves five hundred (500) connections or less and includes a collection system with a system size of six (6) points or ~~less~~ fewer on the Idaho Department of Environmental Quality (DEQ) system classification rating form and is limited to only one (1) of the following wastewater treatment processes: aerated lagoons; non-aerated lagoon(s); primary treatment; or primary treatment discharging to a large soil absorption system (LSAS). (7-1-24)()

03. System Classifications. All other system classifications used here are in accordance with DEQ classifications. ()

003. -- 099. (RESERVED)

100. LICENSURE.

01. Classifications.

License Type	Classification
Drinking Water Distribution Operator Drinking Water Treatment Operator	Operator-In-Training, Very Small System, Class I Restricted, Class I, II, III, or IV
Wastewater Treatment Operator Wastewater Collections Operator	Operator-In-Training, Very Small System, Class I Restricted, Class I, II, III, IV, or Land Application
Wastewater Laboratory Analyst Backflow Assembly Tester	Class I, II, III, or IV

License Discipline	License Type	Classification
<u>Drinking Water</u>	<u>Drinking Water Distribution Operator</u>	<u>Operator-In-Training, Class I Restricted,</u> <u>Class I, II, III, or IV</u>
	<u>Drinking Water Treatment Operator</u>	<u>Operator-In-Training, Class I Restricted,</u> <u>Class I, II, III, or IV</u>
		<u>Very Small Drinking Water Systems</u>

License Discipline	License Type	Classification
Wastewater	Wastewater Treatment Operator	Operator-In-Training, Class I Restricted, Class I, II, III, IV, or Land Application
	Wastewater Collections Operator	Operator-In-Training, Class I Restricted, Class I, II, III, or IV
	Wastewater Laboratory Analyst	Class I, II, III, or IV
		Very Small Wastewater Systems
Backflow Assembly Tester	Backflow Assembly Tester	BAT

(7-1-24)()

02. Examination Requirement. ~~Applicants must pass a written examination for each license type and classification.~~ Applicants may apply and test for the classification level for which they have the requisite experience and education. Examination scores are valid for one (1) year from the examination date. (7-1-24)()

03. Education and Experience Requirements. Applicants must present proof of the following:

(7-1-24)

a. Operator-In-Training. Passage of the board-approved examination or enrollment in a board-approved apprenticeship program. The Operator-In-Training license is valid for five (5) years. (7-1-24)

b. Very Small Drinking Water. Eighty-eight (88) hours of relevant on-site operating experience ~~at a water system~~ and twelve (12) hours of chlorination and drinking water distribution course(s). (7-1-24)()

c. Very Small Wastewater. Eighty-eight (88) hours of relevant on-site operating experience ~~at a wastewater collection or treatment system~~; six (6) hours of pumps and motors or collection course(s); and six (6) hours of lagoon operation and maintenance, large soil absorption system, or wastewater treatment course(s). (7-1-24)()

d. Class I Restricted. Two hundred sixty (260) hours of relevant on-site operating experience ~~at a Class I or higher system~~ during twelve (12) consecutive months with ~~the a~~ system and sixteen (16) hours of continuing education relevant to the license. A restricted license is limited to a specific system. (7-1-24)()

e. ~~Class I Operator. One thousand six hundred (1,600) hours of on-site operating experience at a Class I or higher system, or 3200 hours of experience at a Very Small Wastewater System, or successful completion of one (1) year of an approved apprenticeship program.~~ Class I Operator. One thousand six hundred (1,600) hours of relevant on-site operating experience, or successful completion of a board approved Class I apprenticeship program. (7-1-24)()

f. ~~Class II Operator. Four thousand eight hundred (4,800) hours of on-site operating experience at a Class I or higher system or successful completion of an approved apprenticeship program.~~ Class II Operator. Four thousand eight hundred (4,800) hours of relevant on-site operating experience or successful completion of a board approved Class II apprenticeship program. (7-1-24)()

g. ~~Class III Operator. Two (2) years of postsecondary education in environmental control, engineering or related science or successful completion of an approved apprenticeship program and six thousand four hundred (6,400) hours of on-site operating experience, including three thousand two hundred (3,200) hours of responsible charge of a major segment of the system, at a Class II or higher system.~~ Class III Operator. Two (2) years of postsecondary education in environmental control, engineering or related science or successful completion of a board approved Class III apprenticeship program; and six thousand four hundred (6,400) hours of relevant on-site operating experience. (7-1-24)()

h. ~~Class IV Operator. Four (4) years of postsecondary education in environmental control, engineering or related science or successful completion of an approved apprenticeship program; and six thousand~~

~~four hundred (6,400) hours of on-site operating experience, including three thousand two hundred (3,200) hours of responsible charge of a major segment of the system, at a Class III or higher system~~Class IV Operator. Four (4) years of postsecondary education in environmental control, engineering or related science or successful completion of a board approved Class IV apprenticeship program; and six thousand four hundred (6,400) hours of relevant on-site operating experience. (7-1-24)()

i. Wastewater Land Application. ~~A wastewater Class I or higher operation license and eight hundred (800) hours of on-site operating experience at a wastewater land application system. A wastewater land application operator who is in responsible charge must be licensed at a class equal to or greater than the wastewater system classification. The wastewater treatment license must be maintained to renew the wastewater land application~~Operator must hold and maintain an active Wastewater Treatment Operator license. (7-1-24)()

j. Backflow Assembly Tester. Successful completion of a ~~B~~board-approved training program and passage of a practical examination using the University of Southern California (USC) testing procedures ~~or other testing procedures approved by the board.~~ (7-1-24)()

k. Class I Wastewater Laboratory Analyst. One thousand six hundred (1,600) hours of lab experience ~~at a Class I or higher system.~~ (7-1-24)()

l. Class II Wastewater Laboratory Analyst. Four thousand eight hundred (4,800) hours of lab experience ~~at a Class I or higher system~~ at a drinking water or wastewater laboratory. (7-1-24)()

m. Class III Wastewater Laboratory Analyst. Two (2) years of postsecondary education in environmental control, engineering or related science and six thousand four hundred (6,400) hours of lab experience ~~at a Class II or higher system~~ at a drinking water or wastewater laboratory. (7-1-24)()

n. Class IV Wastewater Laboratory Analyst. Four (4) years of postsecondary education in environmental control, engineering or related science and six thousand four hundred (6,400) hours of lab experience ~~at a Class III or higher system~~ at a drinking water or wastewater laboratory. (7-1-24)()

04. Substitutions. An applicant may substitute education and experience requirements as follows: (7-1-24)

a. Completion of an apprenticeship program will be accepted in lieu of education or experience requirements as identified in Rule 100.03 if the program provides experience and education related to the operation of Class I-IV systems; is registered with the U.S. Department of Labor, Office of Apprenticeship; meets the Standards of Apprenticeship developed by the U.S. Department of Labor; and fulfills the requirements in Rules 100.03. (7-1-24)

b. Education for Experience. For Classes I, II, III and IV, postsecondary education in environmental control, engineering or related science can be substituted for up to fifty percent (50%) of the required experience, at a rate of thirty (30) college ~~semester~~ credits or ~~forty-five~~ four hundred fifty (450) hours equivalent to forty-five (45) CEUs of germane continuing education for one thousand six hundred (1,600) hours of experience. Education substituted for experience must be in addition to the minimum education requirement. For non-environmental, engineering, or science related degrees only courses germane to these disciplines will be eligible for substitution as determined by the board. (7-1-24)()

c. Experience for Education. One thousand six hundred (1,600) hours of on-site operating experience may be substituted for ~~one (1) year of high school~~ each year of post secondary education. ~~For Class III and IV, responsible charge experience may be substituted for postsecondary education at a rate of one thousand six hundred (1,600) hours of experience for one (1) year postsecondary education.~~ Experience substituted for education must be in addition to the minimum experience requirement. (7-1-24)()

d. Experience for Experience. Fifty percent (50%) of the required operating experience must be met by relevant, onsite operating experience in the license type being applied for. The following experience may be used to substitute up to fifty percent (50%) of the required operating experience: (7-1-24)()

i. Environmental or operations consultants, or environmental or engineering branch of federal, state, county, or local government; ()

ii. Construction of a distribution, collections, or *drinking* water or wastewater treatment system if such experience is documented in a declaration from a system owner or licensed operator, or; ()

iii. Experience in the license disciplines of Drinking Water and Wastewater. ()

ie. Laboratory Analyst Experience for Experience. Experience as a laboratory analyst may count towards ~~one-half (1/2)~~ fifty percent (50%) of the required wastewater operating experience and experience as a wastewater operator may count towards ~~one-half (1/2)~~ fifty percent (50%) of the required laboratory analyst experience. (7-1-24)()

ii- ~~The following experience may be substituted for one-half (1/2) of the operating experience requirement for Class I, II, III and IV: environmental or operations consultant; environmental or engineering branch of federal, state, county, or local government; wastewater collection system operator; wastewater treatment plant operator; water distribution system operator or manager; and/or waste treatment operation or maintenance. (7-1-24)~~

iii- ~~The following experience may be substituted for one-half (1/2) of the operating experience requirement for Class I and II: construction of a water or wastewater distribution or collections system if such experience is documented in a declaration from a system owner or licensed operator. (7-1-24)~~

05. Board approved Backflow or Operator Examination Providers Monitored and Audited. The board or its representative may monitor and audit any board approved examination provider. ()

056. **Continuing Education.** To renew, a licensee must complete, ~~during the prior licensing period,~~ and retain proof of completion of six (6) classroom hours (0.6 CEUs) for each year of the licensing period of continuing education germane to the license ~~type discipline (*Drinking Water or Wastewater*),~~ except that backflow assembly testers must complete an eight (8) hour refresher course every two (2) years. ~~A licensee holding both drinking water and wastewater licenses must complete six (6) classroom hours for each license type.~~ A remote or distant study course is acceptable if it is germane to the license type, except that backflow assembly testers must complete in-person and board-approved continuing education. (7-1-24)()

a. A licensee may carry forward up to six (6) classroom hours of unused continuing education (0.6 CEUs) per licensure discipline for up to one (1) renewal cycle. ()

b. A licensee who is an instructor for a *drinking* water or wastewater continuing education course may be credited the same number of classroom hours as the students of the germane course for one (1) presentation of the training per year of the licensing period. ()

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. **Operator-in-Training.** Operators-in-training must practice under the direct supervision of an appropriately licensed operator ~~of a type, category, and classification higher than the operator-in-training. No operator-in-training can accept or perform the designated responsible charge duties at any system. (7-1-24)()~~

02. **Grandparent License.** ~~The licensee may operate in responsible charge of the specific facility identified in the original application. The license is site specific, non-transferable, and does not grant authority for the holder to practice as an operator at any other system. The license becomes invalid when the classification of the system changes to a higher classification. (7-1-24)~~

032. **Operators and Backflow Assembly Testers Code of Conduct.** Operators and backflow assembly testers must: (7-1-24)

- a. Perform duties with due care and diligence to protect the safety, health, and welfare of the public. (7-1-24)
- b. Comply with all applicable local, state, and federal laws relating to their respective profession(s). (7-1-24)
- c. Perform only those duties within their education, training, and experience and scope of licensure. (7-1-24)
- d. Prepare reports which are accurate, objective, and include all relevant information. (7-1-24)
- e. Use standard test procedures, operating procedures, methods, and equipment when conducting inspections, sampling, and field tests with calibrated equipment. (7-1-24)
- f. Backflow assembly testers will observe or inspect existing installations of backflow prevention assemblies to identify whether the assembly is properly installed the assembly is adequate for the degree of hazard. (7-1-24)
- g. When a backflow prevention assembly passes a field test, the tester must submit the report ~~will be submitted~~ to the consumer and relevant public water system within fifteen (15) business days of the field test. ()
- h. When a backflow prevention assembly is defective or fails to pass the field test, the tester must submit the report ~~will be submitted~~ to the consumer and relevant public water system within two (2) business days of the field test. (7-1-24)()

[Proposed new Subsection 200.02.h. has been withdrawn]

201. -- 399. (RESERVED)

400. FEES.

All fees are non-refundable. Annual fees may be aggregated for biennial licensure.

TYPE	AMOUNT APPLICATION (Not to Exceed)	ANNUAL RENEWAL (Not to Exceed)
<u>Application</u>	<u>\$25</u>	
<u>Backflow Assembly Tester</u>	<u>\$100</u>	<u>\$85</u>
<u>Operator-In-Training</u>	<u>\$55</u>	<u>N/A</u>
<u>Very Small System</u>	<u>\$75</u>	<u>\$60</u>
<u>Land Application</u>	<u>\$80</u>	<u>\$65</u>
<u>Class I & Restricted Class I</u>	<u>\$80</u>	<u>\$65</u>
<u>Class II</u>	<u>\$90</u>	<u>\$75</u>
<u>Class III</u>	<u>\$100</u>	<u>\$85</u>
<u>Class IV</u>	<u>\$100</u>	<u>\$85</u>
<u>Endorsement</u>	<u>\$100</u>	<u>N/A</u>
License	~~\$30 annually~~ <u>75</u>	<u>N/A</u>
Reinstatement <u>Fee</u>	<u>\$35</u>	<u>N/A</u>

(7-1-24)()

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.06.01 – RULES FOR THE LICENSURE OF OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

DOCKET NO. 24-0601-2501 (FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis \(CBA\)](#)

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 67-2604\(1\)\(g\)](#), Idaho Code, and [Section 54-3712](#), 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:

Reinstatement fees have been removed from the fee table to allow reinstatements to be standardized at \$35, pursuant to [Section 67-2614\(9\)](#), Idaho Code.

The text of the pending rule has been amended in accordance with [Section 67-5227](#), Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 1, 2025, Idaho Administrative Bulletin, [Vol. 25-10, pages 313–314](#).

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:

As authorized in Section 54-3712, Idaho Code, the fees in this rulemaking are increased by one hundred (100) percent of the current fees. Despite the increase, Idaho's fees will remain competitive with, or lower than, those in comparable states. This adjustment is necessary to comply with the cash balance expectations of [Section 67-2608\(3\)](#), Idaho Code.

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 on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

DATED this 30th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
PO Box 83720
Boise, ID 83720-0063
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to [Section 67-2604\(1\)\(g\)](#), Idaho Code, and [Section 54-3712](#), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2025.

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:

An amendment to Rule 400 regarding a potential increase in fees to address the Occupational Therapy Licensure Board's cash balances.

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

The increase proposed is one hundred (100) percent of the current fees. However, with the increase Idaho's licensing fees will remain at or below those in comparable states. Fee authorized by [Section 54-3712](#), Idaho Code. This increase is necessary to comply with the cash balance expectations of [Section 67-2608\(3\)](#), Idaho Code.

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\(1\)](#), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 7, 2025 Idaho Administrative Bulletin, [Vol. 25-5, Pages 54-55](#).

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) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 13th day of August, 2025.

THE FOLLOWING IS THE TEXT OF FEE DOCKET NO. 24-0601-2501

Italicized red text that is *double underscored* indicates amendments to the proposed text as adopted in the pending rule.

**24.06.01 – RULES FOR THE LICENSURE OF OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS**

400. FEES.

All fees are non-refundable. *Annual fees may be aggregated for biennial licensure.*

FEE TYPE	AMOUNT (Not to Exceed)	<u>ANNUAL</u> RENEWAL FEE (Not to Exceed)
Initial Licensure for Occupational Therapists	\$ ~~80~~ <u>160</u>	\$ ~~40~~ <u>80</u>
Initial Licensure for Occupational Therapy Assistants	\$ ~~60~~ <u>120</u>	\$ ~~30~~ <u>70</u>
Limited Permit or Temporary License	\$ ~~25~~ <u>50</u>	
<u>Reinstatement Fee</u>	<u>As provided in Section 67-2614, Idaho Code.</u>	

(7-1-24)()

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.09.01 – RULES OF THE BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS

DOCKET NO. 24-0901-2501 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 54-1605\(2\) and \(4\)](#), 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 chapter is proposed to be repealed and replaced with Docket No. 24-4101-2501. [2025 HB 28](#) merged two Boards within the Division to create the newly established Board of Long-Term Care Administrators. This rulemaking will merge the substance of the predecessor Board rules, approved by the Legislature in 2025, into a new chapter of rules for the merged Board. As such, the chapters of 24.09.01 and 24.19.01 are consolidated into what is proposed to be entitled IDAPA 24.41.01 – Rules of the Long-Term Care Administrators Board.

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 October 1, 2025, Idaho Administrative Bulletin, [Vol. 25-10, page 315](#).

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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

DATED this 30th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
PO Box 83720
Boise, ID 83720-0063
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to [Section 54-1605\(2\)](#) and [54-1605\(4\)](#), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2025.

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

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

This chapter is proposed to be repealed and replaced with Docket No. 24-4101-2501. [2025 HB 28](#) merged two Boards within DOPL to create the newly established Board of Long-Term Care Administrators. This rulemaking will merge the substance of the predecessor Board rules, approved by the Legislature in 2025, into a new chapter of rules for the merged Board. As such, the chapters of 24.09.01 and 24.19.01 are consolidated into what is proposed to be entitled IDAPA 24.41.01 – Rules of the Long-Term Care Administrators Board.

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\(2\)](#), Idaho Code, separate negotiated rulemaking was not conducted because negotiated rulemaking was held for Docket No. 24-4101-2501 regarding the creation of the new merged rules chapter.

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) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2025.

DATED this 28th day of August, 2025.

IDAPA 24.09.01 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.13.01 – RULES GOVERNING THE PHYSICAL THERAPY LICENSURE BOARD

DOCKET NO. 24-1301-2501 (FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis \(CBA\)](#)

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 67-2604\(1\)\(g\)](#), Idaho Code, and [Section 54-2207](#), 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:

Reinstatement fees have been removed from the fee table to allow reinstatements to be standardized at \$35, pursuant to [Section 67-2614\(9\)](#), Idaho Code.

The text of the pending rule has been amended in accordance with [Section 67-5227](#), Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 1, 2025, Idaho Administrative Bulletin, [Vol. 25-10, pages 316–317](#).

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:

As authorized in Section 54-2207, Idaho Code, the fees in this rulemaking are increased by fifty (50) percent of the current fees. Despite the increase, Idaho's fees will remain competitive with, or lower than, those in comparable states. This adjustment is necessary to comply with the cash balance expectations of [Section 67-2608\(3\)](#), Idaho Code.

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 on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

DATED this 30th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
PO Box 83720
Boise, ID 83720-0063
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to [Section 67-2604\(1\)\(g\)](#), Idaho Code, and [Section 54-2207](#), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2025.

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:

An amendment to Rule 400 regarding a potential increase in fees to address the Physical Therapy Licensure Board's cash balances.

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

The increase proposed is fifty (50) percent of the current fees. However, with the increase Idaho's licensing fees will remain at or below those in comparable states. Fee authorized by [Section 54-2207](#), Idaho Code. This increase is necessary to comply with the cash balance expectations of [Section 67-2608\(3\)](#), Idaho Code.

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\(1\)](#), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 7, 2025 Idaho Administrative Bulletin, [Vol. 25-5, Pages 56-57](#).

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) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 13th day of August, 2025.

THE FOLLOWING IS THE TEXT OF FEE DOCKET NO. 24-1301-2501

Italicized red text that is *double underscored* indicates amendments to the proposed text as adopted in the pending rule.

24.13.01 – RULES GOVERNING THE PHYSICAL THERAPY LICENSURE BOARD

400. FEES.

All fees are non-refundable. The examination or reexamination fee are in addition to the application fee and must accompany the application. *Annual fees may be aggregated for biennial licensure.*

FEE TYPE	AMOUNT <i><u>(NOT TO EXCEED)</u></i>	<i><u>ANNUAL</u></i> RENEWAL FEE <i><u>(NOT TO EXCEED)</u></i>
Physical Therapist License	\$ ~~25~~ <i><u>40</u></i>	\$ ~~25~~ <i><u>40</u></i>
Physical Therapist Assistant License	\$ ~~20~~ <i><u>30</u></i>	\$ ~~20~~ <i><u>30</u></i>
Examination	Established by examination entity plus an administrative fee not to exceed \$ ~~20~~ <i><u>25</u></i>	
Application	\$ ~~25~~ <i><u>40</u></i>	

(7-1-24)()

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.17.01 – RULES OF THE STATE BOARD OF ACUPUNCTURE

DOCKET NO. 24-1701-2501 (FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis \(CBA\)](#)

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 67-2604\(1\)\(g\)](#), Idaho Code, and [Section 54-4705\(1\)\(c\)](#), 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:

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 October 1, 2025, Idaho Administrative Bulletin, [Vol. 25-10, pages 318–320](#).

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:

As authorized in [Section 54-4710\(2\)](#), Idaho Code, the fees in this rulemaking are increased by one hundred (100) to one hundred fifty (150) percent of the current licensure fees, with a slightly higher adjustment for renewals. Despite the increase, Idaho's fees will remain competitive with, or lower than, those in comparable states. This adjustment is necessary to comply with the cash balance requirements outlined in [Section 67-2608\(3\)](#), Idaho Code.

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 on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

DATED this 30th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
PO Box 83720
Boise, ID 83720-0063
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to [Section 67-2604\(1\)\(g\)](#), Idaho Code, and [Section 54-4705\(1\)\(c\)](#), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2025.

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:

An amendment to Rule 400 regarding a potential increase in fees to address the Board of Acupuncture's cash balances, as well as clarifications to certification, supervision, and discipline provisions.

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

The increase proposed is one hundred (100) percent to one hundred fifty (150) percent of the current fees for licensure and slightly more for renewals. However, with the increase Idaho's fees will remain competitive or lower than those in comparable states. Fee authorized by [Section 54-4710\(2\)](#), Idaho Code. This increase is necessary to comply with the cash balance expectations of [Section 67-2608\(3\)](#), Idaho Code.

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\(1\)](#), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 7, 2025 Idaho Administrative Bulletin, [Vol. 25-5, Pages 58-59](#).

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) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 13th day of August, 2025.

THE FOLLOWING IS THE TEXT OF FEE DOCKET NO. 24-1701-2501

24.17.01 – RULES OF THE STATE BOARD OF ACUPUNCTURE

000. LEGAL AUTHORITY.

~~These rules are promulgated pursuant to Section 54-4705, Idaho Code.~~

~~(3-28-23)()~~

(BREAK IN CONTINUITY OF SECTIONS)

100. QUALIFICATIONS FOR LICENSURE OR CERTIFICATION.

01. Requirements for Licensure. Applicants for licensure must submit a complete application on a Board approved form, required fee, and official certified documentation of ~~either~~: ~~(3-28-23)()~~

a. Certification from NCCAOM or graduation from an approved full-time acupuncture program of at least one thousand seven hundred twenty-five (1,725) hours of entry-level acupuncture education which includes a minimum of one thousand (1000) hours of didactic course work and five hundred (500) clinical hours of practice; and (3-28-23)

b. Successful completion of an acupuncture internship, or other equivalent experience as approved by the Board. (3-28-23)

02. ~~Requirements for Certification.~~ As prescribed in Idaho Code § 54-4707. ~~(3-28-23)~~

(BREAK IN CONTINUITY OF SECTIONS)

105. CONTINUING EDUCATION REQUIREMENTS.

The content of a continuing education course must be germane to the practice of acupuncture as defined in [Section 54-4702, Idaho Code](#). All practitioners are required to complete a minimum of thirty (30) hours of board approved continuing education within the preceding twenty-four (24) months. (3-28-23)

01. Credit for Teaching or Supervision. Licensees may earn up to ten (10) hours of continuing education credit by teaching Board-approved courses or ~~supervision of~~ ~~supervising~~ trainees. ~~(3-28-23)()~~

02. Board Approval. Approved continuing education courses are those courses, programs, and activities that are approved or provided by NCCAOM, accredited acupuncture and oriental medicine schools, or other courses that may be approved by the board. Other courses may be approved based upon documentation submitted by the licensee or course provider. All requests for approval or pre-approval of educational programs are made in writing and include the name of the instructor or instructors, the course agenda, and the number of credit hours requested. (3-28-23)

(BREAK IN CONTINUITY OF SECTIONS)

201. SUPERVISION PLAN.

A licensed or certified acupuncturist providing supervision to trainees shall be responsible for the services provided

by such individuals. Failure to adequately supervise such an individual may subject the supervisor to discipline.
(3-28-23)

01. Supervision. For the first one hundred (100) hours of practice, the supervisor must provide supervision in the treatment room when the trainee is providing treatment. The supervisor will meet with the trainee in person at least monthly to review case studies and demonstrate acupuncture point location and needle placement technique. Before providing treatment without in-person supervision, the trainee must successfully complete a Blood Borne Pathogen course and comprehensive examination that incorporates clean needle techniques and Occupational Safety and Health Administration (OSHA) procedures and requirements.
(3-28-23)()

02. Documentation. Supervision document~~ation~~ will include: charting, diagnosis, and treatment plans, ~~and will include~~ the completion of twenty-five (25) case studies, and verification ~~and documentation~~ of the hours of supervision and case studies. The supervisor and trainee will maintain records of supervision, including summary of case studies in progress or completed by the trainee under supervision, treatment plan for each patient, and the dates of supervision.
(3-28-23)()

03. Termination of Supervision or Change in Supervisor. A supervisor may terminate supervision at any time by submitting written notice of termination to the Board.
(3-28-23)

202. – 299. (RESERVED)

300. DISCIPLINE.

01. Civil Fine. The Board may impose a civil fine not to exceed one thousand dollars (\$1,000) upon a licensee for each violation of Section 54-4711, Idaho Code.
(3-28-23)

02. Costs and Fees. The Board may order a licensee to pay the costs and fees incurred by the Board in the investigation or prosecution of the licensee for violation of Section 54-4711, Idaho Code.
(3-28-23)

03. Advertising. A practitioner who disseminates or causes the dissemination of any advertisement or performs advertising including offers, statements, or other representations, which is in any way fraudulent, false, deceptive, or misleading, may be subject to discipline by the Board.
(3-28-23)

04. Unlicensed or Unsupervised Practice. Knowingly aided or abetted any person to practice acupuncture who is not authorized to practice acupuncture as provided in this chapter or failed to adequately supervise a trainee or auxiliary staff who have contact with patients which creates or results in an unreasonable risk of harm to the patient.
(3-28-23)

301. -- 399. (RESERVED)

400. FEES.

All fees are non-refundable. Annual fees may be aggregated for biennial licensure.

License/Certification/Permit/Certification	Initial Fee (Not to Exceed)	Annual Renewal Fee (Not to Exceed)
Application	\$50	n/a
License	~~\$150~~ 300	~~\$75~~ 200
Certification	~~\$150~~ 300	~~\$75~~ 200
Acupuncture Trainee	\$150	~~\$50~~ 100
Inactive License or Certification	n/a	\$50
Reinstatement	\$250	n/a

(3-28-23)()

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.19.01 – RULES OF THE BOARD OF EXAMINERS OF RESIDENTIAL CARE FACILITY ADMINISTRATORS

DOCKET NO. 24-1901-2501 (CHAPTER REPEAL)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 54-1605\(2\) and \(4\)](#), 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 chapter is proposed to be repealed and replaced with Docket No. 24-4101-2501. [2025 HB 28](#) merged two Boards within the Division to create the newly established Board of Long-Term Care Administrators. This rulemaking will merge the substance of the predecessor Board rules, approved by the Legislature in 2025, into a new chapter of rules for the merged Board. As such, the chapters of 24.09.01 and 24.19.01 are consolidated into what is proposed to be entitled IDAPA 24.41.01 – Rules of the Long-Term Care Administrators Board.

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 October 1, 2025, Idaho Administrative Bulletin, [Vol. 25-10, page 321](#).

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:

No fiscal impact on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

DATED this 30th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
PO Box 83720
Boise, ID 83720-0063
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to [Section 54-1605\(2\)](#) and (4), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2025.

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

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

This chapter is proposed to be repealed and replaced with Docket No. 24-4101-2501. [2025 HB 28](#) merged two Boards within DOPL to create the newly established Board of Long-Term Care Administrators. This rulemaking will merge the substance of the predecessor Board rules, approved by the Legislature in 2025, into a new chapter of rules for the merged Board. As such, the chapters of 24.09.01 and 24.19.01 are consolidated into what is proposed to be entitled IDAPA 24.41.01 – Rules of the Long-Term Care Administrators Board.

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\(2\)](#), Idaho Code, separate negotiated rulemaking was not conducted because negotiated rulemaking was held for Docket No. 24-4101-2501 regarding the creation of the new merged rules chapter.

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) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATE this 28th day of August, 2025.

IDAPA 24.19.01 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.23.01 – RULES OF THE SPEECH, HEARING, AND COMMUNICATION SERVICES LICENSURE BOARD

DOCKET NO. 24-2301-2501 (FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis \(CBA\)](#)

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 54-2910\(3\)](#), Idaho Code and [Section 54-2916B\(1\)](#), Idaho Code.

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

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 October 1, 2025, Idaho Administrative Bulletin, [Vol. 25-10, pages 326–329](#).

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:

As authorized in [Section 54-2916B\(1\)](#), Idaho Code, the fee amount in this rulemaking for Video Remote Interpreting Providers, set at \$150 per five interpreters, was selected by the Board to maintain the expected cash balance while continuing to deliver necessary services.

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 on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Kolby Reddish, Chief Legal Counsel, at (208) 817-6126.

DATED this 30th day of October, 2025.

Kolby K. Reddish
Chief Legal Counsel
PO Box 83720
Boise, ID 83720-0063
Phone: (208) 817-6126
Email: kolby.reddish@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant [Section 54-2910\(3\)](#), Idaho Code and [Section 54-2916B\(1\)](#), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2025.

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 rule adds a license type for Sign Language Video Interpreting, and accompanying fee, as required by [Section 54-2916B](#), Idaho Code. Additionally, the Board seeks to add an equivalency option for required exams for Hearing Instrument Specialist Licensure.

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

The Board selected the fee amount (\$150 per five interpreters) to allow the Board to keep the expected cash balance while continuing to deliver the necessary services.

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\(1\)](#), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the August 6, 2025 Idaho Administrative Bulletin, [Vol. 25-8, Pages 167-168](#).

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) 577-2519.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October, 22, 2025.

DATED this 13th day of August, 2025.

THE FOLLOWING IS THE TEXT OF FEE DOCKET NO. 24-2301-2501

**24.23.01 – RULES OF THE SPEECH, HEARING, AND COMMUNICATION
SERVICES LICENSURE BOARD**

100. LICENSURE.

01. Audiologist Licensure. (3-28-23)

a. Approved Examination. Pass the audiology examination given by PRAXIS. (3-28-23)

b. Approved Experience. Successfully complete a supervised academic clinical practicum as part of a doctoral program that satisfies Section 54-2912(b), Idaho Code, or supervised postgraduate experience that is substantially equivalent to such a practicum. An applicant who has insufficient supervised experience as part of the doctoral program may obtain the necessary experience under a provisional permit as provided in these rules. (3-28-23)

02. Speech Language Pathologist Licensure. (3-28-23)

a. Approved Examination. Pass an examination in speech-language pathology given by PRAXIS. (3-28-23)

b. Approved Supervised Experience. Satisfactorily complete the supervised postgraduate experience approved by the Board as follows: (3-28-23)

i. Complete a minimum of three hundred fifty (350) hours of clinical practicum under the supervision of a licensed speech language pathologist. (3-28-23)

ii. Complete thirty-six (36) weeks of supervised clinical fellowship. (3-28-23)

03. Speech Language Pathologist Assistant Licensure. All applicants for licensure as a speech-language pathologist assistant must comply with the following education and examination requirements: (3-28-23)

a. Approved Education. An associate degree from a nationally accredited school of speech-language pathology with a curriculum approved by the Board. (3-28-23)

b. Approved Examination. Pass an examination in speech-language pathology assistant offered by the American Speech-Language Hearing Association. (3-28-23)

c. Supervision. A speech-language pathologist assistant must work under the supervision of a speech-language pathologist. (3-28-23)

04. Hearing Instrument Specialist Licensure. (3-28-23)

a. Approved Education. A high school diploma or GED. (3-28-23)

b. Approved Examination. Pass the ~~national~~ International Hearing Instrument Studies examination and the practical examination, or equivalent approved by the Board. (~~3-28-23~~)()

- 05. Sign Language Interpreter Licensure.** (3-28-23)
- a.** Education. Possess a high school diploma or the equivalent. (3-28-23)
- b.** Examination or certification. Pass written and practical or performance competency examination approved by the Board or hold a current certification approved by the Board. (3-28-23)
- i.** Written examinations approved by the Board include but are not limited to: The Educational Interpreter Performance Assessment (EIPA), any interpreting generalist written examination developed by the Registry of Interpreters for the Deaf (RID), the Center for Assessment of Sign Language Interpreters (CASLI), or any state government. (3-28-23)
- ii.** Practical or performance examinations approved by the Board include but are not limited to: any practical or performance general interpreting examination recognized by the Registry of Interpreters for the Deaf (RID) or the Educational Interpreter Performance Assessment (EIPA) at score 4.0 or above. The practical or performance examination must have been passed within ten (10) years before the date of original application for licensure. (3-28-23)
- iii.** Certifications approved by the Board include, but are not limited to, those administered by: Registry of Interpreters for the Deaf (RID); National Association of the Deaf (NAD); Center for Assessment of Sign Language Interpreters (CASLI); Board for Evaluation of Interpreters (BEI) at basic level or above, or if certified before 2014, at intermediate level or above; Utah Interpreter Program (UIP) at professional or master level, or a Utah Certified: Deaf Interpreter (UC:DI). (3-28-23)
- 06. Deaf Interpreters.** (3-28-23)
- a.** Letter of Endorsement. Persons who are deaf or hard-of-hearing and are not sign language interpreters may perform sign language interpreting services in the role of a deaf interpreter if they file the approved application with the Board and include one (1) written endorsement letters from sign language interpreters licensed by the Board. Deaf Interpreters must complete this process on a yearly basis. (3-28-23)
- b.** Withdrawal of Endorsement. A sign language interpreter who has endorsed a deaf interpreter may withdraw their endorsement at any time upon delivery of written notice to the deaf interpreter and the Board. (3-28-23)
- 07. Temporary Registration for Out-Of-State Applicants.** (3-28-23)
- a.** Registration. A person licensed or certified in good standing as a sign language interpreter in another state, territory, or the District of Columbia may practice sign language interpreting in this state without a license issued by the Board for a period of thirty (30) days within a twelve (12) month period, provided they pay the required fee and meet the requirements of this section. The Board may grant an extension or additional registrations for good cause. (3-28-23)
- b.** Statement of Registration. Before commencing such work, the person will file with the Board on a form approved by the board a statement of registration providing the person's name, residence, sign language interpreter license or certificate of registration number, and the name, address, and phone number of the issuing authority. (3-28-23)
- 08. Continuing Education.** (3-28-23)
- a.** Requirement. Each licensee will successfully complete, in the twelve (12) months preceding each renewal of their license, a minimum of ten (10) contact hours of continuing education directly related to the scope of their practice and sponsored by a national, state, or regional professional association or an institution of higher education. (3-28-23)
- i.** For college or university courses that are approved by the Board for continuing education credit, one (1) semester credit hour equals fifteen (15) contact hours; one (1) quarter credit hour equals ten (10) contact

hours. (3-28-23)

ii. For proctoring the hearing aid dealing and fitting examination administered by the Board, a licensee may claim three (3) contact hours per exam up to a total of six (6) contact hours during each year, provided that a licensee may not claim more than nine (9) contact hours during any three (3) year period. (3-28-23)

b. Documentation. Each licensee must maintain documentation verifying hours of attendance. This documentation is subject to audit and must be provided upon request. (3-28-23)

(BREAK IN CONTINUITY OF SECTIONS)

400. FEES.

1. **Non-refundable.** ~~All f Fees are non-refundable. Fees are established in accord with Title 54, Chapter 29, Idaho Code as follows:~~ (3-28-23)

~~for~~ License, Permit, and Registration ~~Fees are as follows. Annual fees may be aggregated for biennial licensure.~~

LICENSE/PERMIT/REGISTRATION	INITIAL FEE (Not to Exceed)	ANNUAL RENEWAL FEE (Not to Exceed)
Application	\$30	
Original or Endorsement	\$70	\$100
Provisional Permit or Extension	\$100	
Registration Out-of-State Licensee	\$10	
Reinstatement fee	As provided in Section 67-2614, Idaho Code.	
<u>Video Remote Interpreting Provider</u>	<u>\$150 (for up to five employed sign language interpreters, and for every five thereafter</u>	<u>\$150 (for up to five employed sign language interpreters, and for every five thereafter</u>

(3-28-23)()

02. **Examination Fees.** The examination fee is that charged by the examination provider plus an administration fee of one hundred dollars (\$100) when the examination is administered by the Board. (3-28-23)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.26.01 – RULES OF MIDWIFERY

DOCKET NO. 24-2601-2501

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 [67-2604](#), 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 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](#). These pending rules adjust permit fees downwards to address the Board's cash balance, while simultaneously reducing costs for licensees.

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 November 5, 2025, Idaho Administrative Bulletin, [Vol. 25-11, pages 105-106](#).

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:

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to finalize the Board's authority to temporarily reduce fees when necessary. Under this pending fee rule, promulgated through temporary rulemaking earlier this year, the Division implemented fee reductions of thirty percent (30%) to ninety-six percent (96%) for four (4) of the Board's license fees beginning January 1, 2025.

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 on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ryan Bernard, Legislative and Regulatory Affairs Chief, at (775) 870-7926.

DATED this 5th day of December, 2025.

Ryan Bernard
Legislative and Regulatory Affairs Chief
PO Box 83720
Boise, ID 83720-0063
Phone: (775) 870-7926
Email: ryan.bernard@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to [Section 67-2604](#), 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.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-2601-2501

24.26.01 – RULES OF MIDWIFERY

400. FEES.

~~Unless otherwise provided for, all fees are non-refundable.~~ ~~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 – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 [67-2604](#), 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 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](#). These pending rules add 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.

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 November 5, 2025, Idaho Administrative Bulletin, [Vol. 25-11, pages 107-108](#).

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:

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to finalize the Board's authority to temporarily reduce fees when necessary. Under this pending fee rule, promulgated through temporary rulemaking earlier this year, the Division implemented fee reductions of ten percent (10%) to twenty-six percent (26%) for three (3) of the Board's license/permit fees beginning January 1, 2025.

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 on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ryan Bernard, Legislative and Regulatory Affairs Chief, at (775) 870-7926.

DATED this 5th day of December, 2025.

Ryan Bernard
Legislative and Regulatory Affairs Chief
PO Box 83720
Boise, ID 83720-0063
Phone: (775) 870-7926
Email: ryan.bernard@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. 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.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-3101-2501

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 – ADOPTION OF PENDING RULE

[LINK: LSO Rules Analysis Memo](#)

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 67-2604, 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 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](#). These pending rules add 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.

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 November 5, 2025, Idaho Administrative Bulletin, [Vol. 25-11, pages 109-110](#).

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:

There are no newly imposed or increased fees in this rule change. Instead, this rulemaking seeks to finalize the Board's authority to temporarily reduce fees when necessary. Under this pending fee rule, promulgated through temporary rulemaking earlier this year, the Division implemented fee reductions of seven percent (7%) to thirty-six percent (36%) for nine (9) of the Board's license fees beginning January 1, 2025.

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 on the state general fund will occur as a result of these changes.

ASSISTANCE WITH TECHNICAL QUESTIONS: For assistance with technical questions concerning this pending rule, contact Ryan Bernard, Legislative and Regulatory Affairs Chief, at (775) 870-7926.

DATED this 5th day of December, 2025.

Ryan Bernard
Legislative and Regulatory Affairs Chief
PO Box 83720
Boise, ID 83720-0063
Phone: (775) 870-7926
Email: ryan.bernard@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with [Section 67-5221\(1\)](#), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to [Section 67-2604](#), 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.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-3401-2501

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	<u>Not more than \$25</u>	<u>Not more than \$25</u>	<u>Not more than \$25</u>	
Initial Application Fee			<u>Not more than \$90</u>	
License by Exam Fee	<u>Not more than \$90</u>	<u>Not more than \$75</u>	<u>Not more than \$90</u>	
License by Endorsement	<u>Not more than \$110</u>	<u>Not more than \$110</u>		
License Renewal	<u>Not more than \$90</u>	<u>Not more than \$90</u>	<u>Not more than \$90</u>	<u>Not more than \$35</u>
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.

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03. Other Fees:

~~Records Verification Fee~~	~~\$35~~

(3-28-23)