IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Medicaid

16.03.26 – Medicaid Plan Benefits

Who does this rule apply to?
For those receiving medical assistance under Idaho Medicaid.

What is the purpose of this rule?
This chapter of rules contains the general provisions regarding the administration of the Medical Assistance Program (Medicaid).

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statutes passed by the Idaho Legislature:

Public Assistance and Welfare -
Public Assistance Law:
- Section 56-202(b), Idaho Code – Duties of Director of State Department of Health & Welfare
- Section 56-265, Idaho Code – Provider Payment

Where can I find information on Administrative Appeals?
Administrative appeals and contested cases are governed by the provisions of IDAPA 62.01.01, "Idaho Rules of Administrative Procedure."

How do I request public records?
Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records."

Who do I contact for more information on this rule?

Idaho Department of Health and Welfare
Division of Medicaid
450 W. State Street,
Boise, ID 83702

P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5747 or 1-877-200-5441 (toll free)
Fax: (208) 364-1811
Email: DHWRules@dhw.idaho.gov
Webpage: https://medicaid.idaho.gov

ARCHIVE

Table of Contents

16.03.26 – Medicaid Plan Benefits

000. Legal Authority. 13
001. Scope. 13
002. Incorporation By Reference. 13
003. Background Check Requirements. 13
004. (Reserved) 14
005. Definitions: A Through H. 14
006. Definitions: I Through O. 16
007. Definitions: P Through Z. 18
008. – 009. (Reserved) 20

GENERAL PARTICIPANT PROVISIONS

010. Medical Assistance Procedures. 20
011. Choice Of Providers. 20
012. Participant Responsibility. 20
013. – 019. (Reserved) 20

GENERAL PROVIDER PROVISIONS

020. Individual Provider Requirements. 20
021. Provider Application Process. 20
022. Provider Agreements. 21
023. – 024. (Reserved) 22
025. Conditions For Payment. 22
026. Third-Party Liability. 23
027. – 029. (Reserved) 24
030. General Payment Procedures. 24
031. Handling Of Overpayments And Underpayments For Specified Providers. 26
032. – 034. (Reserved) 27
035. Records. 27
036. – 039. (Reserved) 27

GENERAL REIMBURSEMENT PROVISIONS FOR INSTITUTIONAL PROVIDERS

040. Documentation For Audits. 27
041. – 044. (Reserved) 27
045. Related Party Transactions. 28
046. (Reserved) 28
047. Long-Term Care Facility Payment. 28
048. – 049. (Reserved) 28

SPECIFIC PROVIDER REIMBURSEMENT

050. NF And ICF/IID Reimbursement. 28
051. PCS And Aged And Disabled Waiver Service Cost Surveys. 36
052. Specialized Reimbursement: Certain HCBS And CHIS. 36
053. Accounting Treatment. 38
054. Specialized Reimbursement: Electronic Visit Verification (EVV). 39
055. Exception To The Related Organization Principle. 39

PROOF ARCHIVE

056. – 059. (Reserved) 40
EXCLUDED SERVICES
060. Services, Treatments, And Procedures Not Covered By Medicaid. 40
061. Investigational Procedures Or Treatments. 41
062. – 069. (Reserved) 41
MEDICAID BASIC PLAN COVERED SERVICES
SUB AREA: HOSPITAL SERVICES
070. Hospital Services: Definitions. 41
071. Inpatient Hospital Services: Coverage And Limitations. 44
072. Inpatient Hospital Services: Procedural Requirements. 44
073. Inpatient Hospital Services: Provider Qualifications And Duties. 44
074. Hospital Services: Provider Reimbursement. 44
075. Inpatient Hospital Services: Quality Assurance. 48
076. – 079. (Reserved) 49
080. Outpatient Hospital Services: Definitions. 49
081. (Reserved) 49
082. Outpatient Hospital Services: Coverage And Limitations. 49
083. Outpatient Hospital Services: Procedural Requirements. 49
084. (Reserved) 49
085. Outpatient Hospital Services: Provider Reimbursement. 49
086. – 089. (Reserved) 50
SUB AREA: AMBULATORY SURGICAL CENTERS
090. – 091. (Reserved) 50
092. Ambulatory Surgical Center Services: Coverage And Limitations. 50
093. (Reserved) 50
094. Ambulatory Surgical Center Services: Provider Qualifications And Duties. 50
095. Ambulatory Surgical Center Services: Provider Reimbursement. 50
096. – 099. (Reserved) 50
SUB AREA: CASE MANAGEMENT SERVICES
100. Case Management. 50
101. Case Management: Participant Eligibility. 50
102. Case Management: Coverage And Limitations. 50
103. (Reserved) 51
104. Case Management: Provider Qualifications And Duties. 51
105. – 109. (Reserved) 51
SUB AREA: MEDICAL SERVICES
110. Medical Services. 51
111. Medical Services: Participant Eligibility. 51
112. Medical Services: Coverage And Limitations. 51
113. Medical Services: Procedural Requirements. 52
114. Medical Services: Provider Qualifications And Duties. 52
115. – 118. (Reserved) 52
119. Medical Services: Diagnostic Screening Clinics. 52

SUB AREA: OTHER PROVIDER SERVICES
120. Chiropractic Services: Definitions. 52
121. (Reserved) 52
122. Chiropractic Services: Coverage And Limitations. 52
123. – 130. (Reserved) 53
131. Diabetes Education And Training Services: Participant Eligibility. 53
132. Diabetes Education And Training Services: Coverage And Limitations. 53
133. Diabetes Education And Training Services: Procedural Requirements. 53
134. Diabetes Education And Training Services: Provider Qualifications And Duties. 53
135. – 139. (Reserved) 53
140. Licensed Midwife (LM) Services. 53
141. LM Services: Participant Eligibility. 53
142. LM Services: Coverage and Limitations. 54
143. – 145. (Reserved) 54
146. LM Services: Provider Quality Assurance Activities. 54
147. – 149. (Reserved) 54
150. Nutritional Services. 54
151. – 161. (Reserved) 54
162. Optometrist Services: Coverage And Limitations. 54
163. – 169. (Reserved) 54
170. Podiatrist Services: Definitions. 54
171. Podiatrist Services: Participant Eligibility. 54
172. Podiatrist Services: Coverage And Limitations. 55
173. – 179. (Reserved) 55
SUB AREA: CHIS
180. CHIS: Definitions. 55
181. CHIS: Eligibility Requirements. 55
182. CHIS: Coverage And Limitations. 55
183. CHIS: Procedural Requirements. 57
184. CHIS: Provider Qualifications And Duties. 58
185. CHIS: Provider Reimbursement. 60
186. CHIS: Quality Assurance. 60
187. – 189. (Reserved) 60
SUB AREA: PREVENTION SERVICES
190. Preventive Health Assistance (PHA): Definitions. 60
191. Preventive Health Assistance (PHA): Participant Eligibility. 61
192. Preventive Health Assistance (PHA): Coverage And Limitations. 61
193. Preventive Health Assistance (PHA): Procedural Requirements. 61
194. (Reserved) 61
195. Preventive Health Assistance (PHA): Provider Reimbursement. 61
196. Early Intervention Services. 62
197. – 199. (Reserved) 62
SUB AREA: LABORATORY AND RADIOLOGY SERVICES

200. Laboratory And Radiology Services: Definitions. 62
201. – 202. (Reserved) 62
203. Laboratory And Radiology Services: Coverage And Limitations. 62
204. Laboratory And Radiology Services: Provider Qualifications And Duties. 62
205. Laboratory And Radiology Services: Provider Reimbursement. 62
206. Laboratory And Radiology Services: Quality Assurance. 63
207. – 209. (Reserved) 63

SUB AREA: PRESCRIPTION DRUGS

210. Prescription Drugs: Definitions. 63
211. Prescription Drugs: Participant Eligibility. 63
212. Prescription Drugs: Coverage And Limitations. 63
213. Prescription Drugs: Procedural Requirements. 65
214. Prescription Drugs: Provider Qualifications And Duties. 65
215. Prescription Drugs: Provider Reimbursement. 65
216. – 219. (Reserved) 68

SUB AREA: FAMILY PLANNING

220. (Reserved) 68
221. Family Planning Services: Participant Eligibility. 68
222. Family Planning Services: Coverage And Limitations. 69
223. Family Planning Services: Procedural Requirements. 69
224. (Reserved) 69
225. Family Planning Services: Provider Reimbursement. 70
226. – 229. (Reserved) 70

SUB AREA: BEHAVIORAL HEALTH SERVICES

230. (Reserved) 70
231. Behavioral Health Services: Participant Eligibility. 70
232. Behavioral Health Services: Coverage And Limitations. 70
233. Behavioral Health Services: Procedural Requirements. 70
234. Behavioral Health Services: Provider Qualifications And Duties. 70
235. Behavioral Health Services: Provider Reimbursement. 70
236. – 239. (Reserved) 70

SUB AREA: HOME HEALTH SERVICES

240 – 241. (Reserved) 71
242. Home Health Services: Coverage And Limitations. 71
243. Home Health Services: Procedural Requirements. 71
244. Electronic Visit Verification (EVV). 71
245. (Reserved) 71
246. Home Health Services: Provider Reimbursement. 71
247. – 249. (Reserved) 72

SUB AREA: THERAPY SERVICES

250. Therapy Services: Definitions. 72
251. Therapy Services: Participant Eligibility. 73
252. Therapy Services: Coverage And Limitations. 73

PROPOSED

253. Therapy Services: Procedural Requirements. 74
254. (Reserved) 74
255. Therapy Services: Provider Reimbursement. 74
256. Therapy Services: Quality Assurance Activities. 74
257. – 259. (Reserved) 75

SUB AREA: AUDIOLOGY SERVICES

260. Audiology Services. 75
261. (Reserved) 75
262. Audiology Services: Coverage And Limitations. 75
263. Audiology Services: Procedural Requirements. 75
264. – 269. (Reserved) 76

SUB AREA: DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

270. – 271. (Reserved) 76
272. DMEPOS: Coverage And Limitations. 76
273. DMEPOS: Procedural Requirements. 76
274. (Reserved) 77
275. DMEPOS: Provider Reimbursement. 77
276. DMEPOS: Quality Assurance. 77
277. – 279. (Reserved) 78

SUB AREA: VISION SERVICES

280. – 281. (Reserved) 78
282. Vision Services: Coverage And Limitations. 78
283. – 284. (Reserved) 78
285. Vision Services: Provider Reimbursement. 78
286. – 289. (Reserved) 78

SUB AREA: DENTAL SERVICES

290. Dental Services: Selective Contract For Dental Coverage. 78
291. Dental Services: Definitions. 79
292. Dental Services: Participant Eligibility. 79
293. Dental Services: Coverage And Limitations. 79
294. Dental Services: Procedural Requirements. 79
295. Dental Services: Provider Qualifications And Duties. 79
296. Dental Services: Provider Reimbursement. 79
297. Dental Services: Quality Assurance. 79
298. – 299. (Reserved) 79

SUB AREA: ESSENTIAL PROVIDERS

300. FQHC And RHC Services: Definitions. 80
301. – 302. (Reserved) 80
303. FQHC And RHC Services: Coverage And Limitations. 80
304. – 305. (Reserved) 81
306. FQHC And RHC Services: Reimbursement Methodology. 81
307. FQHC And RHC: Rate Setting Methodology. 81

308. – 311. (Reserved) 83
312. Indian Health Service (IHS) Clinic Services: Coverage And Limitations. 83
313. – 314. (Reserved) 83
315. Indian Health Service (IHS) Clinic Services: Provider Reimbursement. 83
316. – 319. (Reserved) 83
320. School-Based Service: Definitions. 83
321. SBS: Participant Eligibility. 83
322. SBS: Service-Specific Participant Eligibility. 83
323. SBS: Coverage And Limitations. 84
324. SBS: Procedural Requirements. 87
325. SBS: Provider Qualifications And Duties. 88
326. SBS: Provider Reimbursement. 92
327. SBS: Quality Assurance And Improvement. 93
328. – 329. (Reserved) 93

SUB AREA: MEDICAL TRANSPORTATION SERVICES

330. (Reserved) 93
331. Emergency Transportation Services: Participant Eligibility. 93
332. Emergency Transportation Services: Coverage And Limitations. 93
333. Emergency Transportation Services: Procedural Requirements. 93
334. Emergency Transportation Services: Provider Qualifications And Duties. 94
335. Emergency Transportation Services: Provider Reimbursement. 94
336. – 339. (Reserved) 95
340. NEMT Services: Definitions. 95
341. NEMT Services: Duties Of The Transportation Broker. 95
342. NEMT Services: Coverage And Limitations. 96
343. NEMT Services: Reimbursement Methodology. 97
344. – 349. (Reserved) 97

SUB AREA: EPSDT SERVICES

350. EPSDT Services: Definitions. 97
351. EPSDT Services: Participant Eligibility. 97
352. EPSDT Services: Coverage And Limitations. 97
353. (Reserved) 98
354. EPSDT Services: Provider Qualifications And Duties. 98
355. – 359. (Reserved) 98

SUB AREA: SPECIFIC PREGNANCY-RELATED SERVICES

360. Pregnancy-Related Services: Definitions. 98
361. (Reserved) 98
362. Pregnancy-Related Services: Coverage And Limitations. 98
363. (Reserved) 98
364. Pregnancy-Related Services: Provider Qualifications And Duties. 98
365. Pregnancy-Related Services: Provider Reimbursement. 99
366. – 449. (Reserved) 99

MEDICAID ENHANCED PLAN COVERED SERVICES

PROPOSED

SUB AREA: ORGAN TRANSPLANTS
450. – 451. (Reserved) 99
452. Organ Transplants: Coverage And Limitations. 99
453. – 454. (Reserved) 99
455. Organ Transplants: Reimbursement. 99
456. – 459. (Reserved) 99
SUB AREA: PRIVATE DUTY NURSING (PDN)
460. PDN: Definitions. 99
461. PDN: Participant Eligibility. 99
462. PDN: Limitations. 100
463. (Reserved) 100
464. PDN: Provider Qualifications And Duties. 100
465. – 469. (Reserved) 101
SUB AREA: NURSING FACILITIES (NF)
470. NF: Definitions. 101
471. NF: Eligibility. 101
472. NF: Patient Liability. 101
473. NF: Coverage And Limitations. 102
474. NF: Procedural Responsibilities. 103
475. Preadmission Screening And Resident Review Program (PASRR). 103
476. NF: Eligibility Coordination And Specialized Service Needs. 104
477. NF: Prepayment Screen And Determination Of Entitlement To Medicaid Payment For NF Care And Services. 104
478. NF: Provider Qualifications And Duties. 104
479. – 480. (Reserved) 104
481. NF: Cost Limits. 104
482. NF: Rate Setting. 104
483. NF: Principle For Rate Setting. 105
484. NF: Rate Development. 105
485. NF: Out-Of-State Facilities. 105
486. NF: Distressed Facility. 105
487. NF: Reviews. 105
488. NF: Behavioral Care Unit (BCU) Rates. 106
489. NF: BCU Qualifications. 106
490. NF: BCU Eligible Days. 106
491. NF: Special Rates. 106
492. NF: Occupancy Adjustment Factor. 107
493. NF: Recapture Of Depreciation. 107
494. NF: Nurse Aide Training And Competency Evaluation Programs (NATCEPS). 108
495. NF: Payments For Temporary Absences. 108
496. – 499. (Reserved) 108
SUB AREA: ICF/IID
500. (Reserved) 108
501. ICF/IID: Participant Eligibility. 108

IAC ARCHIVE 2025

ARCHIVE

502. ICF/IID: Coverage And Limitations. 109
503. ICF/IID: Procedural Responsibilities. 110
504. ICF/IID: Provider Qualifications And Duties. 111
505. ICF/IID: Reimbursement. 111
506. (Reserved) 111
507. ICF/IID: Allowable Costs. 111
508. ICF/IID: Non-Allowable Costs. 112
509. (Reserved) 113
510. ICF/IID: Occupancy Adjustment Factor. 113
511. ICF/IID: Recapture Of Depreciation. 113
512. ICF/IID: Reporting System. 113
513. ICF/IID: Reporting System Principle And Application. 114
514. (Reserved) 115
515. ICF/IID: Principle Prospective Rates. 115
516. ICF/IID: Property Reimbursement. 115
517. ICF/IID: Capped Cost. 115
518. (Reserved) 116
519. ICF/IID: Retrospective Settlement. 116
520. ICF/IID: Exempt Costs. 116
521. ICF/IID: Costs Excluded From Cap. 116
522. (Reserved) 116
523. ICF/IID: Property Rental Rate Reimbursement. 116
524. ICF/IID: Property Reimbursement Limitations. 118
525. ICF/IID: Special Rates. 118
526. – 529. (Reserved) 118

SUB AREA: HOME AND COMMUNITY-BASED SERVICES (HCBS)

530. HCBS. 119
531. HCBS Exceptions. 119
532. (Reserved) 119
533. HCBS: Provider Qualifications And Duties. 119
534. (Reserved) 119
535. Exceptions To Residential Provider-Owned Or Controlled Setting Qualities. 119
536. HCBS Person-Centered Plan Requirements. 119
537. – 538. (Reserved) 120
539. HCBS: Participant Eligibility. 120

SUB AREA: AGED AND DISABLED (A&D) WAIVER SERVICES

540. A&D Waiver Services: Definitions. 120
541. A&D Waiver Services: Eligibility. 120
542. A&D Waiver Services: Coverage And Limitations. 121
543. A&D Waiver Services: Procedural Requirements. 124
544. A&D Waiver Services: Provider Qualifications And Duties. 125
545. A&D Waiver Services: Provider Reimbursement. 127
546. – 548. (Reserved) 127

SUB AREA: TRANSITION MANAGEMENT

ARCHIVE

549. Transition Management. 127
SUB AREA: PERSONAL CARE SERVICES (PCS)
550. PCS: Definitions. 128
551. PCS: Eligibility. 128
552. PCS: Coverage And Limitations. 128
553. PCS: Procedural Requirements. 129
554. PCS: Provider Qualifications And Duties. 130
555. PCS: Reimbursement. 131
556. PCS: Quality Improvement (QI). 132
557. – 559. (Reserved) 132
SUB PART: ENHANCED DD SERVICES
560. DD Services: Requirements. 132
561. DD Determination Standards: Participant Eligibility. 132
562. (Reserved) 134
563. DD Determination Standards: Test Instruments. 134
564. DD Services: Quality Improvement. 134
565. (Reserved) 135
566. DD Services: Administrative Appeals. 135
567. (Reserved) 135
568. Adult DD Services: Definitions. 135
569. Adult DD Services: Eligibility Determination. 136
570. (Reserved) 136
571. Adult DD Services: Coverage And Limitations. 136
572. Adult DD Services: Procedural Requirements. 136
573. Adult DD Services: Service Plan Requirements. 136
574. Adult DD Services: Provider Reimbursement. 138
575. – 579. (Reserved) 139
SUB-PART: CHILDREN'S DD HCBS STATE PLAN OPTION
580. Children's DD HCBS State Plan Option: Definitions. 139
581. Children's DD HCBS State Plan Option: Eligibility Determination. 139
582. Children's DD HCBS State Plan Option: Coverage And Limitations. 140
583. Children's DD HCBS State Plan Option: Service Plan. 141
584. Children's DD HCBS State Plan Option: Procedural Requirements. 142
585. Children's DD HCBS State Plan Option: Provider Qualifications And Duties. 142
586. Children's DD HCBS State Plan Option: Reimbursement. 143
587. – 589. (Reserved) 143
ADULT DD HCBS STATE PLAN OPTION
590. Adult DD HCBS State Plan Option. 143
591. Adult DD HCBS State Plan Option: Eligibility. 143
592. Community Crisis Supports. 143
593. Community Crisis Supports: Coverage And Limitations. 143
594. – 599. (Reserved) 143
600. Developmental Therapy. 143

601. (Reserved) 143
602. Developmental Therapy: Coverage And Limitations. 143
603. Developmental Therapy: Individual Service Plan (ISP) Requirements. 144
604. Developmental Therapy: Individual Program Plan (IPP) Procedural Requirements. 144
605. Developmental Therapy: Procedural Requirements. 145
606. Developmental Therapy: Provider Qualifications And Duties. 146
607. Staffing Requirements. 147
608. – 609. (Reserved) 148

ADULT DD HCBS WAIVER SERVICES

610. Adult DD Waiver Services. 148
611. Adult DD Waiver Services: Participant Eligibility. 148
612. Adult DD Waiver Services: Coverage And Limitations. 148
613. Adult DD Waiver Services: Procedural Requirements. 151
614. Adult DD Waiver Services: Provider Qualifications And Duties. 151
615. Adult DD Waiver Services: Provider Reimbursement. 153
616. – 619. (Reserved) 153
620. Health Home. 153
621. Health Home: Eligibility Requirements. 153
622. Health Home: Coverage And Limitations. 153
623. Health Home: Procedural Requirements. 153
624. Health Home: Provider Qualifications And Duties. 153
625. Health Home: Provider Reimbursement. 153
626. – 629. (Reserved) 153

SUB AREA: SERVICE COORDINATION

630. Service Coordination: Definitions. 153
631. Service Coordination: Participant Eligibility. 154
632. Service Coordination: Coverage And Limitations. 154
633. Service Coordination: Procedural Requirements. 155
634. Service Coordination: Provider Qualifications And Duties. 156
635. Service Coordination: Plan Development – Assessment. 157
636. Service Coordination Plan. 157
637. Service Coordination: Reimbursement. 157
638. – 639. (Reserved) 158

YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION

640. YES HCBS State Plan Option: Independent Assessment. 158
641. YES HCBS State Plan Option: Redetermination. 158
642. YES HCBS State Plan Option: Coverage And Limitations. 158
643. – 649. (Reserved) 158

SUB AREA: HOSPICE

650. Hospice. 158
651. Hospice: Definitions. 158
652. Hospice: Eligibility. 158
653. Hospice: Coverage And Limitations. 159

654. Hospice: Procedural Requirements. 159
655. Hospice: Provider Qualifications And Duties. 160
656. Hospice: Reimbursement. 160
657. Hospice: Inpatient Payment Limitations. 161
658. Hospice: Physician Payments. 161
659. Hospice: Reimbursement Cap. 161
660. Hospice: Patient Liability. 162
661. – 959. (Reserved) 162

DUAL ELIGIBLES

SUB AREA: MEDICARE SAVINGS PROGRAM

960. Medicare Savings Program. 162
961. – 969. (Reserved) 163

SUB AREA: MEDICARE/MEDICAID COORDINATED PLAN (MMCP)

970. Managed Care For Duals. 163
971. Managed Care For Duals: Definitions. 163
972. Managed Care For Duals: Program Authority. 163
973. Managed Care For Duals: Eligibility And Enrollment. 163
974. Managed Care For Duals: Coverage And Limitations. 164
975. – 979. (Reserved) 164

INVESTIGATIONS, AUDITS, AND ENFORCEMENT

SUB AREA: LIENS AND ESTATE RECOVERY

980. (Reserved) 164
981. Liens And Estate Recovery: Definitions. 164
982. Liens And Estate Recovery: Notification To Department. 165
983. Liens And Estate Recovery: Lien During Lifetime Of Participant. 165
984. Liens And Estate Recovery: Requirements For Estate Recovery. 166
985. Liens And Estate Recovery: Limitations And Exclusions. 167
986. Liens And Estate Recovery: Request For Notice. 168
987. – 989. (Reserved) 169

SUB AREA: PARTICIPANT LOCK-IN

990. Participant Utilization Control Program. 169
991. Lock-In Defined. 169
992. Department Evaluation For Lock-In. 169
993. Criteria For Lock-In. 169
994. Lock-In Participant Notification. 170
995. Lock-In Procedures. 170
996. Penalties For Lock-In Noncompliance. 170
997. Appeal Of Lock-In. 171
998. Recipient Explanation Of Medicaid Benefits (REOMBs). 171
999. (Reserved) 171

PREVIEW

000. LEGAL AUTHORITY.
The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), and 56-265, Idaho Code. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Department-Issued Variances. (7-1-25)T

a. The Department may allow variances to clearance requirements under certain circumstances. Applicable providers must still complete an application for a background check. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

04. Providers Subject to Background Check Requirements. (7-1-25)T

a. Adult Day Health Agencies. (7-1-25)T

b. Behavior Consultation or Crisis Management Providers. (7-1-25)T

c. Chore Services Providers. (7-1-25)T

d. Contracted Non-Emergency Medical Transportation (NEMT) Providers, with direct contact with participants except for Individual Contracted NEMT providers. (7-1-25)T

e. Independent CHIS Providers. (7-1-25)T

f. Non-Medical Transportation (NMT) Providers. (7-1-25)T

g. Personal Assistance Agencies (PAA), including PAAs Acting as Fiscal Intermediaries. (7-1-25)T

h. Provider types deemed by the Department to be at high risk for fraud, waste, or abuse. (7-1-25)T

i. Respite Care Providers. (7-1-25)T

j. Service Coordination Agencies. (7-1-25)T

k. Supported Employment Agencies. (7-1-25)T

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. (7-1-25)T

02. Agency. A business entity comprised of an administrator and their employees providing a Medicaid service. Individuals cannot be an agency. (7-1-25)T

03. Adult Day Health (ADH). Defined in Section 67-5006(5), Idaho Code, as adult day care. (7-1-25)T

04. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (7-1-25)T

05. Audit. An examination of provider records and financial records to determine compliance with Medicaid requirements and regulations or quality assurance. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

b. Medicaid CMI. Average of the weighting factors assigned to each Medicaid resident in a facility on the picture date, based on their RUG 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. (7-1-25)T

c. State-Wide Average CMI. Simple average of all facilities "facility-wide" CMIs used to establish the rate limitation July 1st of each year. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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

the Department for payment. (7-1-25)T

12. **CMS**. Centers for Medicare and Medicaid Services. (7-1-25)T

13. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (7-1-25)T

14. **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. (7-1-25)T

15. **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. (7-1-25)T

16. **Department**. The Idaho Department of Health and Welfare or its designee. (7-1-25)T

17. **Director**. The Director of the Department or their designee. (7-1-25)T

18. **Developmental Disability (DD)**. As defined in Section 66-402(5), Idaho Code. (7-1-25)T

19. **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. (7-1-25)T

20. **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. (7-1-25)T

21. **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. (7-1-25)T

22. **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. (7-1-25)T

23. **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). (7-1-25)T

24. **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. (7-1-25)T

25. **Facility**. Facility refers to a hospital, nursing facility (NF), or intermediate care facility for individuals with intellectual disabilities (ICF/IID). (7-1-25)T

26. **Fiscal Intermediary**. An entity that provides services allowing the participant receiving personal assistance services, their designee or legal representative, to choose their level of control for recruiting, selecting, managing, training, and dismissing their personal assistant regardless of the employer of record, and allows the participant control over the way services are delivered. (7-1-25)T

27. 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. (7-1-25)T

006. DEFINITIONS: I THROUGH O.

01. Idaho Medicaid Provider Handbook. A document that contains policy for the implementation and operations of the Medicaid program. (7-1-25)T

02. In-State Care. Medical services not including long-term care provided within Idaho or in counties bordering Idaho. (7-1-25)T

03. Inspection of Care Team (IOCT). Interdisciplinary team providing inspection of care in licensed ICFs/IID composed of: (7-1-25)T

a. An RN; and (7-1-25)T

b. A QIDP; and when required, a: (7-1-25)T

i. Consultant physician; (7-1-25)T

ii. Consultant social worker; or (7-1-25)T

iii. When appropriate, other health and human services employees or consultants of the Department. (7-1-25)T

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. (7-1-25)T

05. Integration. Promoting a lifestyle for home and community-based service (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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

08. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (7-1-25)T

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. (7-1-25)T

10. Licensed Bed Capacity. Number of beds approved by the State's Licensure and Certification Agency for rendering patient care. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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). (7-1-25)T

15. Medical Necessity (Medically Necessary). A service is medically necessary if: (7-1-25)T

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; (7-1-25)T

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; (7-1-25)T

c. It meets any applicable Department criteria. Services that do not meet criteria require a PA; (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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.) (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Participant's name; (7-1-25)T

b. Description of item or service; (7-1-25)T

c. Length of need, if applicable; (7-1-25)T

d. Quantity, if applicable; (7-1-25)T

e. Provider's name, National Provider Identification (NPI) and signature; and (7-1-25)T

f. Date of signature. (7-1-25)T

22. Ordinary. Costs incurred that are customary for normal operation of a business. (7-1-25)T

23. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (7-1-25)T

007. DEFINITIONS: P THROUGH Z.

01. Participant. A person eligible for and enrolled in Medicaid. (7-1-25)T

02. 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. (7-1-25)T

03. 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. (7-1-25)T

04. 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. (7-1-25)T

05. 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. (7-1-25)T

06. 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. (7-1-25)T

07. 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. (7-1-25)T

08. Property Rental Rate. Rate paid per Medicaid patient day to free-standing facilities in lieu of payment for property costs other than property taxes, insurance, and costs of major movable equipment. (7-1-25)T

09. Prosthetic Device. Replacement, corrective, or supportive devices to: (7-1-25)T

a. Artificially replace a missing portion of the body; (7-1-25)T

b. Prevent or correct physical deformities or malfunctions; or (7-1-25)T

c. Support a weak or deformed portion of the body. (7-1-25)T

d. Computerized communication devices are not included in this definition. (7-1-25)T

10. 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. (7-1-25)T

11. Provider Status Review. Written documentation identifying a participant's progress toward goals defined in their service plan. (7-1-25)T

12. Qualified Intellectual Disabilities Professional (QIDP). As described in 42 CFR 483.430(a). (7-1-25)T

13. Quality Improvement Organization (QIO). An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. (7-1-25)T

14. Recoupment. As detailed in IDAPA 16.05.07. (7-1-25)T

15. Recreational Services. Activities 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. (7-1-25)T

16. Referral. A documented recommendation from a healthcare professional to see another Medicaid provider for a specific service. (7-1-25)T

17. 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. (7-1-25)T

18. Resource Utilization Groups (RUG). 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. (7-1-25)T

19. Restrictive Intervention. Any intervention that is used to restrict rights or freedom of movement and includes chemical restraint, mechanical restraint, physical restraint, and seclusion. (7-1-25)T

20. 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. (7-1-25)T

21. Rural Hospital-Based Behavioral Care Unit. A Rural Hospital-Based Provider that qualifies as a behavioral care unit. (7-1-25)T

22. Service Coordination. Case management activity to assist participants with gaining and coordinating access to necessary care and services appropriate to their needs. (7-1-25)T

23. 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. (7-1-25)T

24. Skilled Nursing Care. Level of care for patients requiring twenty-four (24) hour skilled nursing services. (7-1-25)T

25. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (7-1-25)T

26. Supports. Services that provide supervision and assistance to a participant or facilitates integration into the community. (7-1-25)T

27. 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. (7-1-25)T

28. 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. (7-1-25)T

29. 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. (7-1-25)T

30. 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 sheltered workshop or the

general workforce within a year. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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." (7-1-25)T

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: (7-1-25)T

IAC ARCHIVE

a. The provider fails to meet the qualifications required by rule or by any applicable licensing board. (7-1-25)T

b. The provider was a managing employee, or had an ownership interest, in any entity and: (7-1-25)T

i. Previously found by the Department to have engaged in fraudulent or abusive conduct related to the Medicaid program; or (7-1-25)T

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; (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

e. The provider is currently suspended or terminated from Medicare or Medicaid in any state. (7-1-25)T

022. PROVIDER AGREEMENTS.
This section applies to all providers including Family-Directed Community Supports (FDCS). (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Require corrective actions in IDAPA 16.05.07; (7-1-25)T

b. Require a corrective action plan to be submitted by the provider to address noncompliance with requirements; (7-1-25)T

c. Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; (7-1-25)T

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 (7-1-25)T

e. Terminate the provider’s agreement. (7-1-25)T

i. The Department may terminate provider agreements with or without cause by giving written notice to the provider as set forth in the agreement. (7-1-25)T

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. (7-1-25)T

iii. Terminations for cause may be appealed. (7-1-25)T

IAC ARCHIVE 2025

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. The participant received services no earlier than the third month before an application was made on the participant's behalf; (7-1-25)T

b. The provider verified the participant's eligibility on the date of service and can provide proof of the eligibility verification; (7-1-25)T

c. Services provided after the participant's date of death cannot be reimbursed; and (7-1-25)T

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. (7-1-25)T

02. Comply With All Applicable Regulations. (7-1-25)T

03. Comply With the Idaho Medicaid Provider Handbook. (7-1-25)T

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. (7-1-25)T

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

08. Prior Authorization (PA). The Department may require a PA for any service. Unless otherwise specified: (7-1-25)T

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. (7-1-25)T

IAC ARCHIVE 2025

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. (7-1-25)T

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 IDAPA 16.03.05, or IDAPA 16.03.01, and the medical item or service provided is authorized by the Department. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third-party payment, with the following exceptions: (7-1-25)T

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; (7-1-25)T

b. Preventive pediatric care including early and periodic screening, diagnostic, and treatment services which includes: (7-1-25)T

i. Well Child examinations for children under age twenty-one (21) years when provided according to guidance in the Idaho Medicaid Provider Handbook; (7-1-25)T

ii. Diagnosis services to identify the nature of an illness or other problem by examination of the symptoms. (7-1-25)T

c. When PA has been approved under these rules, treatment services to control, correct, or ameliorate health problems found through diagnosis and screenings; (7-1-25)T

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). (7-1-25)T

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. (7-1-25)T

07. Third-Party Payments. The Department will pay the provider the lowest amount of the following: (7-1-25)T

a. The provider's actual charge for the service; (7-1-25)T

b. The maximum allowable charge for the service as established by the Department in its pricing file; or (7-1-25)T

c. The third-party allowed amount minus the third-party payment, or the patient liability as indicated by the third-party. (7-1-25)T

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. (7-1-25)T

a. If litigation or a settlement in such a claim is pursued by the Medicaid participant, the participant must notify the Department. (7-1-25)T

b. If the participant recovers funds from a third party, the participant must repay the amount of benefits paid by the Department. (7-1-25)T

09. Subrogation of Legal Fees. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

027. – 029. (RESERVED)

030. GENERAL PAYMENT PROCEDURES.

01. Provided Services. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

c. The Department is to process each claim received and make payment directly to the provider. (7-1-25)T

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. (7-1-25)T

02. Provider Reimbursement. (7-1-25)T

IAC ARCHIVE 2025

a. The Department will pay the provider the lowest of: (7-1-25)T

i. The provider's actual charge for service; or (7-1-25)T

ii. The maximum allowable charge for the service as established by the Department on its pricing file and Idaho Medicaid Provider Handbook; or (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

i. Historical cost or regional reimbursement data. (7-1-25)T

ii. Percent of charge. (7-1-25)T

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.(7-1-25)T

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. (7-1-25)T

v. Home- and community-based services (HCBS) are priced in accordance with approved service criteria. (7-1-25)T

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. (7-1-25)T

04. Other Noninstitutional Services. The Department will reimburse for noninstitutional services unless otherwise specified. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. The Department makes every effort to issue a notice of program reimbursement within twelve (12) months of receiving a cost report. (7-1-25)T

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. (7-1-25)T

IAC ARCHIVE 2025

07. Procedures for Medicare Cross-Over Claims. (7-1-25)T

a. If a Medicaid participant is eligible for Medicare, the provider must first bill Medicare for the services before billing the Department. (7-1-25)T

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. (7-1-25)T

c. If a provider does not accept a Medicare assignment, an MSN must be submitted with a claim to the Department. (7-1-25)T

d. For all other services, an MSN must be submitted to the Department with a claim. (7-1-25)T

e. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. (7-1-25)T

08. Appeals Process. Reimbursement for services originally denied by the Department will be made if such decision is reversed by the appeals process. (7-1-25)T

031. HANDLING OF OVERPAYMENTS AND UNDERPAYMENTS FOR SPECIFIED PROVIDERS.
This section of rule applies only to providers that are retrospectively cost settled. (7-1-25)T

01. Interest Charges. Medicaid charges interest on overpayments, and pays interest on underpayments, as follows: (7-1-25)T

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. (7-1-25)T

b. When the Department determines an overpayment exists, it may waive interest charges if the administrative costs to collect exceeds the charges. (7-1-25)T

c. The interest rate on overpayments and underpayments is compounded monthly. (7-1-25)T

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. (7-1-25)T

02. Recovery Methods. One (1) of the following will be used for recovery of overpayments: (7-1-25)T

a. Upon receiving a notice of program reimbursement, a provider voluntarily refunds, in a lump sum, the entire overpayment to the Department. (7-1-25)T

b. The provider may: (7-1-25)T

i. Request in writing to make overpayment recovery over a period of twelve (12) months or less; and (7-1-25)T

ii. Submit documentation demonstrating that their financial integrity would be irreparably compromised if repayments occurred over a shorter time period. (7-1-25)T

ARCHIVE

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. (7-1-25)T

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. (7-1-25)T

01. Provider Refusal. Refusal of a provider to permit the Department to review records pertinent to Medicaid will constitute grounds for: (7-1-25)T

a. Withholding payments until access to the requested information is granted; (7-1-25)T

b. Recoupment of payments; or (7-1-25)T

c. Suspending the provider. (7-1-25)T

02. Undocumented Services. Undocumented services are subject to recoupment. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Revenue Documentation. Must include the amount, date, purpose, and source of revenue. (7-1-25)T

04. Additional Documentation. (7-1-25)T

a. Providers are given an opportunity to provide documentation before an interim final audit report is issued. (7-1-25)T

b. Providers are not allowed to submit additional documentation in support of cost items after issuance of the interim final audit report. (7-1-25)T

041. – 044. (RESERVED)

ARCHIVE

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

04. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowed. (7-1-25)T

05. Interest Expense. Interest expense on loans between related entities is not reimbursable under Chapters 2, 10, and 12, PRM. (7-1-25)T

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. (7-1-25)T

a. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Reasonable costs account for both direct and indirect costs of provider services, including normal standby costs. (7-1-25)T

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

IAC ARCHIVE 2025

applicable maximum base rate developed under provisions of Title 56, Idaho Code, or unallowable by application of promulgated regulation. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

04. Application of Related Party Transactions. (7-1-25)T

a. Charges to a provider from related organizations may not exceed the billing to a related organization for these services. (7-1-25)T

b. All home office costs unrelated to patient care are not allowable. (7-1-25)T

05. Compensation to Relatives. Payment for relatives of owners or administrators is allowed only for actual services performed, when necessary, adequately documented, and reasonable. (7-1-25)T

a. Compensation billed to the Department must be included in compensation reported for tax purposes and actually paid. (7-1-25)T

i. When services are performed without pay, no cost may be reported. (7-1-25)T

ii. Time records documenting actual hours worked are required for compensation to allow for reimbursement. (7-1-25)T

iii. Compensation for undocumented work hours is not reimbursable. (7-1-25)T

b. Related persons are defined as these relationships with a provider: (7-1-25)T

i. Spouse; (7-1-25)T

ii. Child or a descendant of a child; (7-1-25)T

iii. Siblings, stepsiblings, or descendant thereof; (7-1-25)T

iv. Parent, stepparent, siblings thereof, and their ancestors; (7-1-25)T

v. Related by marriage; (7-1-25)T

vi. Any other person without an arm’s length relationship. (7-1-25)T

06. Idaho Owner-Administrator Compensation. Allowable compensation to owners and related persons providing any administrative services is limited based on the schedule in this section. (7-1-25)T

a. The following schedule is used to determine the maximum amount of owner administrative compensation. This schedule shows the limits set for 2024 and will be adjusted annually based upon changes in

average hourly earnings in nursing and personal care facilities as published by a nationally recognized forecasting firm. (7-1-25)T

Licensed Bed Range	Upper limit
51 - 100	$161,303
101 - 150	$177,424
151 - 250	$240,940
251 - up	$345,861

(7-1-25)T

b. Maximum allowable compensation for owners providing administrative services is determined by adjusting the schedule as follows: (7-1-25)T

i. To determine the number of beds applicable on the schedule, all licensed beds in any facility an owner provides administrative services to is counted, regardless of whether they are in the same facility. (7-1-25)T

ii. For owners providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds determines the upper limit for allowable compensation. (7-1-25)T

iii. For owners providing services to less than fifty-one (51) beds, administrative related duties are reimbursed at the hourly rate allowable if an owner provided services to fifty-one (51) beds. Services other than administrative services performed by the owner are allowable at the reasonable market rate. To be allowable, hours for each service type is documented. In no event will the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner managing fifty (50) licensed beds or less exceed the limit applicable for an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds. (7-1-25)T

c. Compensation for persons related to an owner is evaluated in the same manner as for an owner. (7-1-25)T

d. When an owner provides services to more than one facility, compensation is distributed on the same basis as costs allocated for non-owners. (7-1-25)T

e. 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.) (7-1-25)T

07. Filing Dates. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

10. Audits. (7-1-25)T

a. All financial reports are subject to audit to: (7-1-25)T

i. Determine that transactions recorded in the books of record are substantially accurate and reliable as a basis to determine reasonable costs. (7-1-25)T

ii. Determine that facility internal controls are sufficiently reliable to disclose the results of a provider's operations. (7-1-25)T

iii. Determine that Medicaid participants received the required care based on economy and efficiency. (7-1-25)T

iv. Determine that GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (7-1-25)T

v. Ensure policies and practices sufficiently meet fiduciary responsibilities for patients, funds, and property. (7-1-25)T

vi. Effect final settlement when required. (7-1-25)T

b. Normally, all annual statements are audited within the following year. (7-1-25)T

c. Other statements and some annual audit recommendations are subject to limited scope audits evaluating provider compliance. (7-1-25)T

d. Additional audits are required for: (7-1-25)T

i. Significant changes of ownership. (7-1-25)T

ii. Changes in management. (7-1-25)T

iii. When an overpayment of twenty-five percent (25%) or more resulted in a completed cost period. (7-1-25)T

e. Annual field audits are by appointment. Auditors identify themselves with a letter of authorization or Department I.D. cards. (7-1-25)T

11. Audit Standards and Requirements. (7-1-25)T

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. (7-1-25)T

b. Examination of records and documents includes: (7-1-25)T

i. Corporate charters or other ownership documents including those for parent or related companies and attachments describing property. (7-1-25)T

ii. Minutes and memos of governing bodies, including committees and its agents. (7-1-25)T

iii. All contracts. (7-1-25)T

iv. Tax returns and records, including workpapers and other supporting documentation. (7-1-25)T

v. All insurance contracts and policies including riders and attachments. (7-1-25)T

vi. Leases. (7-1-25)T

vii. Fixed asset records (see Capitalization of Assets). (7-1-25)T

viii. Schedules of patient charges. (7-1-25)T

ix. Notes, bonds, and other evidence of liabilities. (7-1-25)T

x. Capital expenditure records. (7-1-25)T

xi. Bank statements, canceled checks, deposit slips, and bank reconciliations. (7-1-25)T

xii. Evidence of litigations involving a facility or its owners. (7-1-25)T

xiii. All invoices, statements, and claims. (7-1-25)T

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). (7-1-25)T

xv. Ledgers, journals, all working papers, subsidiary ledgers, records, and documents relating to financial operation. (7-1-25)T

xvi. All patient records, including trust funds and property. (7-1-25)T

xvii. Time studies and other cost determining information. (7-1-25)T

xviii. All other sources of information needed to form an audit opinion. (7-1-25)T

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. (7-1-25)T

d. Adequate expense documentation includes invoices or statements with invoices attached supporting the statement and must include: (7-1-25)T

i. Service or sale date; (7-1-25)T

ii. Terms and discounts; (7-1-25)T

iii. Quantity; (7-1-25)T

IAC ARCHIVE 2025

iv. Price; (7-1-25)T

v. Vendor name and address; (7-1-25)T

vi. Delivery address if applicable; (7-1-25)T

vii. Contract or agreement references; and (7-1-25)T

viii. Description including quantities, sizes, specifications, and brand names of services performed. (7-1-25)T

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. (7-1-25)T

f. Completed depreciation records must include the following for each asset: (7-1-25)T

i. Description of the asset including serial number, make, model, accessories, and location. (7-1-25)T

ii. Cost basis supported by invoices for purchase, installation, etc. (7-1-25)T

iii. Estimated useful life. (7-1-25)T

iv. Depreciation method (straight line, double declining balance, etc.). (7-1-25)T

v. Salvage value. (7-1-25)T

vi. Method of recording depreciation consistent with GAAP. (7-1-25)T

vii. Additional information, such as additional first year depreciation, even when not an allowable expense. (7-1-25)T

viii. Reported depreciation expense for the year and accumulated depreciation tied to the asset ledger. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

i. Lease purchase agreements are generally recognized by any the following characteristics: (7-1-25)T

i. Lessee assumes normal ownership costs, such as taxes, maintenance, etc.; (7-1-25)T

ii. Intent to create security interest; (7-1-25)T

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; (7-1-25)T

iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and (7-1-25)T

v. Initial loan term significantly less than the useful life and lessee has the option to renew at a rental

IAC ARCHIVE 2025

price substantially less than fair rental value. (7-1-25)T

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. (7-1-25)T

k. Complete personnel records including: (7-1-25)T

i. Employment applications. (7-1-25)T

ii. W-4 Forms. (7-1-25)T

iii. Authorizations for any deductions such as insurance, credit union, etc. (7-1-25)T

iv. Routine evaluations. (7-1-25)T

v. Pay raise authorizations. (7-1-25)T

vi. Statements of understanding of policies, procedures, etc. (7-1-25)T

vii. Fidelity bond applications (when applicable). (7-1-25)T

l. A system of internal control intended to provide a method of handling all routine and nonroutine tasks related to: (7-1-25)T

i. Safeguarding assets and resources against waste, fraud, and inefficiency. (7-1-25)T

ii. Promoting accuracy and reliability in financial records. (7-1-25)T

iii. Encouraging and measuring compliance with company policy and legal requirements. (7-1-25)T

iv. Determining the degree of efficiency related to various aspects of operations. (7-1-25)T

m. An adequate system of internal control over cash disbursements including: (7-1-25)T

i. Payment on invoices only, or statements supported by invoices. (7-1-25)T

ii. Authorizations for purchase; a purchase order. (7-1-25)T

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (7-1-25)T

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (7-1-25)T

v. Check of invoice accuracy. (7-1-25)T

vi. Invoice approval policy. (7-1-25)T

vii. Method of invoice cancellation to prevent duplicating payment. (7-1-25)T

viii. Adequate separation of duties between ordering, recording, and paying. (7-1-25)T

ix. System separation of duties between ordering, recording, and paying. (7-1-25)T

x. Signature policy. (7-1-25)T

xi. Pre-numbered checks. (7-1-25)T

IAC ARCHIVE 2025

xii. Statement of policy regarding cash or check expenditures. (7-1-25)T

xiii. Adequate internal control over recording transactions in the books of record. (7-1-25)T

xiv. An imprest system for petty cash. (7-1-25)T

n. Sound accounting practices including: (7-1-25)T

i. Documentation of accounting policies and procedures, including capitalization, depreciation, and expenditure classification criteria. (7-1-25)T

ii. Chart of accounts. (7-1-25)T

iii. Budget or operating plans. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

b. Providers are subject to legal and financial liabilities for committing any of the following acts and any other acts contrary to federal regulations: (7-1-25)T

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. (7-1-25)T

ii. Nothing is to be deducted from these funds, unless deductions are authorized by the patient or their agent in writing. (7-1-25)T

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. (7-1-25)T

c. Fund Management. Proper management includes the following at a minimum: (7-1-25)T

i. Savings accounts, maintained separately from facility funds. (7-1-25)T

ii. An accurate system of supporting receipts and disbursements to patients. (7-1-25)T

iii. Written authorization for all deductions. (7-1-25)T

iv. Signature verification. (7-1-25)T

v. Deposit of all receipts on the same day received. (7-1-25)T

vi. Minimal funds kept in a facility. (7-1-25)T

vii. All funds must always be locked. (7-1-25)T

viii. Policy statement regarding patient's funds and property. (7-1-25)T

ix. Periodic review of all policies with staff in training sessions and with all new employees upon employment. (7-1-25)T

x. System of periodic review and correction of policies and financial records for patient property and funds. (7-1-25)T

IAC ARCHIVE 2025

13. Legal Consultant Fees and Litigation Costs. When these costs are incurred by a provider, they are handled as follows: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. ERE. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Developmental Disability Agencies (DDA) providing services to adults or children; (7-1-25)T

b. Residential Habilitation Agencies; (7-1-25)T

c. Supported Employment Agencies; (7-1-25)T

d. Service Coordination Agencies; and (7-1-25)T

e. CHIS. (7-1-25)T

02. Timing, Description, and Rate Review Results. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

i. Substantiated participant complaints, critical incidents, or both, related to a lack of qualified providers indicate emerging access issues; (7-1-25)T

ii. Department quality reports or substantiated participant complaints and critical incidents related to the quality of services indicate emerging quality issues; or (7-1-25)T

iii. Federal or Idaho minimum wage requirements in effect at the time of a standard rate review significantly change. (7-1-25)T

03. Cost Survey Procedures. The Department conducts periodic cost surveys. Providers who refuse or fail to respond may be disenrolled as a Medicaid provider. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

iii. The Department makes the final determination of BLS occupation profiles. (7-1-25)T

iv. The Department evaluates an appropriate wage inflation factor based on economic data available at the time the rate is set. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

d. General and Administrative (G&A) Expenses are wages and other expenses related to daily operations common across all businesses. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

iii. The G&A% used to calculate a new rate will not exceed ten percent (10%) of the total rate per staff hour. (7-1-25)T

e. Total Rate Per Staff Hour of Service = ((Wage + (ERE% x Wage) + (PRE% x Wage)) / (1-(G&A%)). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

05. Quality Incentives. Based on the quality of services provided, a provider may be eligible for incentive payments. (7-1-25)T

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. (7-1-25)T

b. Incentive payments are subject to availability of State and federal funds and may be rescinded if service quality declines. (7-1-25)T

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. (7-1-25)T

01. Final Payment. Final payment is made based on the reasonable cost of services as determined by audit under these rules. (7-1-25)T

02. Overpayments. Recovery of overpayments is attempted as quickly as possible consistent with the financial integrity of the provider resulting in two (2) circumstances: (7-1-25)T

a. For unfiled cost reports, all payments included in the recovery period and any subsequent payments are due. (7-1-25)T

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. (7-1-25)T

054. SPECIALIZED REIMBURSEMENT: ELECTRONIC VISIT VERIFICATION (EVV).

01. Services Requiring EVV. (7-1-25)T

a. Home Health. (7-1-25)T

b. State Plan PCS. (7-1-25)T

c. Attendant Care, Homemaker and Respite under the A&D Waiver. (7-1-25)T

02. EVV Requirements. Providers must: (7-1-25)T

a. Select and maintain an EVV system and certified as compliant with the Department's MMIS aggregator; (7-1-25)T

b. Retain documented participant consent for the provider's EVV methods; (7-1-25)T

c. Develop and maintain policies and procedures for use of EVV technology, including strategies for safeguarding participant data and privacy; and (7-1-25)T

d. Submit EVV data capturing six (6) system-validated data elements for services rendered: (7-1-25)T

i. Service date; (7-1-25)T

ii. Service start and end times; (7-1-25)T

iii. Direct service provider; (7-1-25)T

iv. Recipient of service; (7-1-25)T

v. Billable service; and (7-1-25)T

vi. Service delivery location. (7-1-25)T

e. Submit EVV data to the State's aggregator prior to billing claims. (7-1-25)T

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: (7-1-25)T

01. Supplying Organization. Is a bona fide separate organization; (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Rental expense for transactions between related entities is not recognized. Costs of ownership are allowed. (7-1-25)T

b. When a facility is purchased from a related entity, the purchaser's depreciable basis will not exceed the seller's net book value. (7-1-25)T

IAC ARCHIVE 2025

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: (7-1-25)T

a. Acupuncture services; (7-1-25)T

b. Naturopathic services; (7-1-25)T

c. Bio-feedback therapy; (7-1-25)T

d. Group hydrotherapy; (7-1-25)T

e. Fertility-related services, including testing; (7-1-25)T

f. Vocational services except for supported employment services; (7-1-25)T

g. Educational services; (7-1-25)T

h. Recreational services; (7-1-25)T

i. Duplicative services; (7-1-25)T

j. Housing except when approved for a medical institution; and (7-1-25)T

k. Food, except when medically necessary or the home-delivered meals benefit. (7-1-25)T

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: (7-1-25)T

a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; (7-1-25)T

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; (7-1-25)T

c. Laetrile therapy; (7-1-25)T

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; (7-1-25)T

e. Drugs supplied to patients for self-administration other than those allowed under these rules; (7-1-25)T

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; (7-1-25)T

IAC ARCHIVE 2025

g. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service; (7-1-25)T

h. Surgical procedures on the cornea for myopia; or (7-1-25)T

i. Services as detailed in Section 56-273, Idaho Code. (7-1-25)T

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: (7-1-25)T

a. The treatment or procedure is in Phase I clinical trials; (7-1-25)T

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 (7-1-25)T

c. Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. (7-1-25)T

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. (7-1-25)T

01. Focused Case Review. A focused case review consists of assessment of: (7-1-25)T

a. Health benefit to the participant; (7-1-25)T

b. Risk to the participant; (7-1-25)T

c. Standard treatment for the participant's condition, including alternative treatments; (7-1-25)T

d. Specific inclusion or exclusion by Medicare national coverage guidelines; (7-1-25)T

e. Phase of the clinical trial of the proposed procedure or treatment; (7-1-25)T

f. Guidance regarding the proposed procedure or treatment by national organizations; (7-1-25)T

g. Pertinent clinical data and peer-reviewed literature; and (7-1-25)T

h. Ethics Committee review, if appropriate. (7-1-25)T

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. (7-1-25)T

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

ARCHIVE

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. (7-1-25)T

02. All-Patient Refined Diagnosis Related Group (APR-DRG). A payment methodology outlined in the Medicaid Provider Agreement. (7-1-25)T

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. (7-1-25)T

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (7-1-25)T

05. Charity Care. Charity care is care provided to individuals who have no source of payment, third-party or personal resources. (7-1-25)T

06. Critical Access Hospitals (CAH). A rural hospital as set forth in 42 CFR Section 485.620. (7-1-25)T

07. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

12. Disproportionate Share Threshold. The disproportionate share threshold is: (7-1-25)T

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (7-1-25)T

b. A Low-Income Revenue Rate exceeding twenty-five percent (25%). (7-1-25)T

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. (7-1-25)T

14. Low-Income Revenue Rate. The Low-Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (7-1-25)T

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 (7-1-25)T

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments' county assistance programs. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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). (7-1-25)T

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.

(7-1-25)T

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. (7-1-25)T

21. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services for hospitals not reimbursed under DRG methodologies: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Payment Procedures. The following procedures are applicable to in-patient hospitals: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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 (7-1-25)T

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

b. The Department will reimburse hospitals for participants under the following conditions: (7-1-25)T

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05; and (7-1-25)T

ii. The participant is authorized for payment of long-term care. (7-1-25)T

c. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

iv. Routine services include all medical care, supplies, and services that are included in the calculation of NF property and nonproperty costs. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Mandatory Eligibility for DSH status will be provided for hospitals that: (7-1-25)T

i. Meet or exceed the disproportionate share threshold under these rules. (7-1-25)T

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (7-1-25)T

(1) This subsection does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (7-1-25)T

(2) Does not offer nonemergency inpatient obstetric services. (7-1-25)T

iii. The MUR will not be less than one percent (1%). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates: (7-1-25)T

(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. (7-1-25)T

(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. (7-1-25)T

vii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding: (7-1-25)T

(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. (7-1-25)T

(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. (7-1-25)T

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: (7-1-25)T

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (7-1-25)T

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third-party payment. (7-1-25)T

ii. Claims of uninsured costs that increase the maximum amount that a hospital may receive as a DSH payment must be documented. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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." (7-1-25)T

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: (7-1-25)T

(1) Recover the overpayment from the provider; and (7-1-25)T

(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. (7-1-25)T

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. (7-1-25)T

05. Out-of-State Hospitals. Hospitals will have a cost settlement computed with the state of Idaho if the following conditions are met: (7-1-25)T

IAC ARCHIVE 2025

a. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Interim rates will be adjusted at least annually based on the best information available to the Department. (7-1-25)T

b. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

01. QIO Information. The QIO's policies, criteria, standards, operating procedures, and forms for

performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. (7-1-25)T

02. Department Provisions. Department-selected diagnoses and procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. (7-1-25)T

03. Approval Timeframe. A provision that the QIO will inform the hospital of a certification within five (5) days, or other time frame as determined by the Department, of an approved admission, transfer, or continuing stay. (7-1-25)T

04. Method of Notice. The method of notice to hospitals of QIO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. (7-1-25)T

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." (7-1-25)T

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. (7-1-25)T

081. (RESERVED)

082. OUTPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.

01. Services Are Provided On-Site. (7-1-25)T

02. Co-Payments. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Follow-Up for Emergency Room Patients. Hospitals must coordinate care of patients who have a PCP. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Community Re-entry Services. Community re-entry services provide targeted case management for eligible incarcerated participants. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

102. CASE MANAGEMENT: COVERAGE AND LIMITATIONS.

01. Home Visiting Coverage. (7-1-25)T

a. Assessment for medical, educational, social, or other service needs; (7-1-25)T

b. Development and revision of a plan to address goals; (7-1-25)T

c. Referral and related activities for necessary services; and (7-1-25)T

d. Monitoring of progress. (7-1-25)T

e. Services do not include case management integral to another covered service or that constitutes direct delivery of referred services. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

111. MEDICAL SERVICES: PARTICIPANT ELIGIBILITY.
The Department will fund abortions under circumstances where the abortion is necessary to save the life of the woman. (7-1-25)T

112. MEDICAL SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Physicals. Adult preventive physical examinations are limited to one (1) per year. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

04. Screening Mammograms. Screening mammograms are covered when aligned with the "A" or "B" recommendations of the United States Preventative Services Task Force. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Photographs of the front, side and underside of the abdomen; (7-1-25)T

b. Treatment of any ulceration and skin infections involving the panniculus; (7-1-25)T

c. Failure of conservative treatment, including weight loss; (7-1-25)T

d. That the panniculus severely inhibits the participant's walking; (7-1-25)T

e. That the participant is unable to wear a garment to hold the panniculus up; and (7-1-25)T

f. Other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Misrepresentation of Services. Any representation of a service provided by a provider other than a physician as a physician service is prohibited. (7-1-25)T

03. Weight Loss Surgical Procedures. Physicians and hospitals performing surgical procedures must meet national medical standards for weight loss surgery. (7-1-25)T

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. (7-1-25)T

01. Multidisciplinary Assessments and Consultations. The clinic must perform on site multidisciplinary assessments and consultations with each participant and responsible parent or guardian. Diagnostic and consultive services related to the diagnosis and treatment of the participant will be provided by board certified provider specialists in physical medicine, neurology and orthopedics. (7-1-25)T

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. (7-1-25)T

03. Provider Qualifications. The clinic will be a separate and distinct entity from the hospital or other provider practices. (7-1-25)T

SUB AREA: OTHER PROVIDER SERVICES
(Sections 120-179)

120. CHIROPRACTIC SERVICES: DEFINITIONS.
Subluxation is partial or incomplete dislocation of the spine. (7-1-25)T

121. (RESERVED)

122. CHIROPRACTIC SERVICES: COVERAGE AND LIMITATIONS.
Only treatment involving manipulation of the spine to correct a subluxation condition is covered. (7-1-25)T

IAC ARCHIVE 2025

123. – 130. (RESERVED)

131. DIABETES EDUCATION AND TRAINING SERVICES: PARTICIPANT ELIGIBILITY.
Medical necessity for diabetes education and training are evidenced by the following: (7-1-25)T

01. Participants with Diabetes. Are eligible for a Diabetes Management Program when: (7-1-25)T

a. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or (7-1-25)T

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 (7-1-25)T

c. Recent manifestations from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. (7-1-25)T

02. Participants with Pre-Diabetes. Are eligible for the National Diabetes Prevention Program when they meet the program's guidance. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Services Limited. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. (7-1-25)T

133. DIABETES EDUCATION AND TRAINING SERVICES: PROCEDURAL REQUIREMENTS.
To receive diabetes counseling, the participant must have a written order and referral. (7-1-25)T

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. (7-1-25)T

02. The National Diabetes Prevention Program. The provider meets the requirements for the program. (7-1-25)T

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. (7-1-25)T

141. LM SERVICES: PARTICIPANT ELIGIBILITY.
LM services are available for participants in maternity, or newborn participants. (7-1-25)T

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. (7-1-25)T

02. Medication. Covered medication listed in the LM formulary under IDAPA 24.26.01. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Chronic Foot Diseases. Chronic foot diseases include: (7-1-25)T

a. Diabetes mellitus; (7-1-25)T

b. Peripheral neuropathy involving the feet; (7-1-25)T

c. Chronic thrombophlebitis; (7-1-25)T

d. Peripheral vascular disease; (7-1-25)T

e. Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds, pressure ulcers, or amputation; or (7-1-25)T

f. Other conditions that have the potential to seriously or irreversibly compromise overall health. (7-1-25)T

171. PODIATRIST SERVICES: PARTICIPANT ELIGIBILITY.
Participants eligible for podiatrist services are those with a(n): (7-1-25)T

01. Chronic Disease. (7-1-25)T

02. Acute Condition. An acute condition that, if left untreated, may cause an adverse outcome to the participant's health. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Aversive Intervention. Uses unpleasant physical or sensory stimuli to reduce undesired behavior. The stimuli usually cannot be avoided or is pain inducing. (7-1-25)T

03. Community. Natural, integrated environments outside the participant's home, outside of DDA center-based settings, or at school outside of school hours. (7-1-25)T

04. Developmental Disabilities Agency (DDA). (7-1-25)T

05. Duplicate Services. (7-1-25)T

a. Goals are not separate and unique to each service provided; or (7-1-25)T

b. When more than one (1) service is provided at the same time, unless otherwise authorized. (7-1-25)T

06. Fidelity. The consistent and accurate implementation of children's habilitation services in accordance with the modality, manual, protocol, or model. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Required Order. CHIS must be ordered by a provider within their scope of practice. (7-1-25)T

a. CHIS providers cannot seek reimbursement for services provided more than thirty (30) calendar days prior to the signed and dated order. (7-1-25)T

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. (7-1-25)T

03. Required Screening. Needs are determined through the current version of the Department-

IAC ARCHIVE 2025

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. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

i. Hospitalization; (7-1-25)T

ii. Out-of-home placement; (7-1-25)T

iii. Incarceration; or (7-1-25)T

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (7-1-25)T

e. The ACTP must contain the following: (7-1-25)T

i. Clinical interviews must be completed with the parent or legal guardian; (7-1-25)T

ii. Objective and validated comprehensive skills or developmental assessment. The most current assessment must be used and be from within the last year; (7-1-25)T

iii. Review of assessments, reports, and relevant history; (7-1-25)T

iv. Observations in at least one (1) environment; (7-1-25)T

v. Clinical summary and recommendations; (7-1-25)T

vi. A transition plan; and (7-1-25)T

vii. Be signed by the individual completing the assessment and the parent or legal guardian. (7-1-25)T

f. Case Management is available to assist participants accessing CHIS by the Department as described in the Medicaid Provider Handbook. (7-1-25)T

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. (7-1-25)T

01. Prior Authorization (PA) Request. Must be submitted to the Department. The provider, and parent or legal guardian will be notified of the decision. (7-1-25)T

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. (7-1-25)T

b. Initial PA requests must include: (7-1-25)T

i. An order from a provider; and (7-1-25)T

ii. The ACTP. (7-1-25)T

c. Ongoing PA requests must include: (7-1-25)T

i. A list of the participant's goals and objectives; (7-1-25)T

ii. A written summary of data regarding progress or lack of progress to meeting each objective, including graphs showing change lines; (7-1-25)T

iii. A list of all CHIS hours being requested and the qualification of the individual(s) who will provide them; and (7-1-25)T

iv. An updated annual ACTP, if applicable. (7-1-25)T

d. The following services may be requested retroactively: (7-1-25)T

i. The initial ACTP; (7-1-25)T

ii. The screening tool; and (7-1-25)T

iii. Crisis intervention within seventy-two (72) hours of the service initiation. (7-1-25)T

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. (7-1-25)T

03. Documentation. For each participant, the following program documentation is required for each visit made or service provided: (7-1-25)T

a. Date, time, and duration; (7-1-25)T

b. Summary of session or service provided, and if interdisciplinary training is provided, who the service was delivered to, and the content covered; (7-1-25)T

c. Data documentation that corresponds to the implementation plans for habilitative skill building or behavioral intervention; (7-1-25)T

d. Location of service delivery; and (7-1-25)T

e. Signature of the individual providing the service, date signed, and credential. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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 experience and competency requirements for an intervention specialist or higher. (7-1-25)T

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: (7-1-25)T

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 (7-1-25)T

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 (7-1-25)T

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 (7-1-25)T

ii. Meets the competency requirements by completing one (1) of the following: (7-1-25)T

(1) A Department-approved competency checklist; or (7-1-25)T

(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. (7-1-25)T

04. Intervention Professional. Intervention professionals can deliver all CHIS and complete assessments and implementation plans. Qualifications are as follows: (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Obtain an independent Medicaid provider agreement through the Department and maintain in good standing; (7-1-25)T

b. Be certified in CPR and first aid prior to delivering services and maintain current certification thereafter; (7-1-25)T

c. Follow all applicable requirements in the CHIS sections; and (7-1-25)T

d. Not receive supervision from an individual that they are directly supervising. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. An elementary education certificate or special education certificate with an endorsement in early childhood special education; or (7-1-25)T

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

(7-1-25)T

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: (7-1-25)T

i. Promotion of development and learning for children from birth to five (5) years of age. (7-1-25)T

ii. Assessment and observation methods that are developmentally appropriate assessment of young children with developmental delays or disabilities; (7-1-25)T

iii. Building family and community relationships to support early interventions; (7-1-25)T

iv. Development of appropriate curriculum for young children; (7-1-25)T

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children and their families; and (7-1-25)T

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-25)T

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. (7-1-25)T

186. CHIS: QUALITY ASSURANCE.
The Department will establish performance criteria to meet federal assurances that measure the outcomes and effectiveness of CHIS. (7-1-25)T

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. (7-1-25)T

02. Quality Improvement. Activities may include any of the following: (7-1-25)T

a. Consultation; (7-1-25)T

b. Technical assistance and recommendations; or (7-1-25)T

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: (7-1-25)T

i. Issuance of a corrective action plan; (7-1-25)T

ii. Reporting to Medicaid Program Integrity Unit; or (7-1-25)T

iii. Action against a provider agreement. (7-1-25)T

187. – 189. (RESERVED)

**SUB AREA: PREVENTION SERVICES
(Sections 190-199)**

190. PREVENTIVE HEALTH ASSISTANCE (PHA): DEFINITIONS.
Behavioral PHA are benefits to support weight control. (7-1-25)T

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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: (7-1-25)T

a. For an adult, a body mass index (BMI) of thirty (30) or higher or eighteen and one-half (18 1/2) or lower. (7-1-25)T

b. For a child, a body mass index (BMI) that falls in either the overweight or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. (7-1-25)T

02. Wellness PHA. A participant who is required to pay premiums for eligibility under SCHIP. (7-1-25)T

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. (7-1-25)T

a. Maximum Benefit Points. (7-1-25)T

i. The maximum number of points for a Behavioral PHA is two hundred (200) each benefit year. (7-1-25)T

ii. The maximum number of points for the Wellness PHA benefit is one hundred twenty (120) each benefit year. (7-1-25)T

b. Points expire at the end of the participant's benefit year. (7-1-25)T

c. Points cannot be transferred to, or combined with, points in another participant's PHA benefit. (7-1-25)T

02. Weight Management Program. Each program must provide weight management services with at least one (1) of the following: (7-1-25)T

a. Physical fitness; (7-1-25)T

b. Balanced diet; or (7-1-25)T

c. Personal health education. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

05. Reference Laboratory. A laboratory that only accepts specimens from other laboratories. (7-1-25)T

201. – 202. (RESERVED)

203. LABORATORY AND RADIOLOGY SERVICES: COVERAGE AND LIMITATIONS.

01. Laboratory Services. (7-1-25)T

02. Radiology Services. (7-1-25)T

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. (7-1-25)T

02. Use of Reference Laboratories. Laboratories using reference laboratories must ensure that all requirements of these rules are met by the reference laboratory. (7-1-25)T

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: (7-1-25)T

a. An independent laboratory that can bill for a reference laboratory; (7-1-25)T

b. A transplant facility that can bill for histocompatibility testing; and (7-1-25)T

c. Healthcare professionals acting within the licensure and scope of their practice to comply with Section 39-909, Idaho Code. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

212. PRESCRIPTION DRUGS: COVERAGE AND LIMITATIONS.

01. General Drug Coverage. Medicaid covers prescription drugs not excluded under this rule that are legally obtainable by the order of a prescriber under Section 54-1705, Idaho Code. (7-1-25)T

02. Preferred Drug List (PDL). (7-1-25)T

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). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Agents, when used to promote smoking cessation. (7-1-25)T

b. Prescription vitamins and mineral products. Covered agents include the following: (7-1-25)T

i. Injectable vitamin B12 (cyanocobalamin and analogues); (7-1-25)T

ii. Vitamin K and analogues; (7-1-25)T

iii. Prescription vitamin D and analogues; (7-1-25)T

iv. Prescription pediatric vitamins, minerals, and fluoride preparations; (7-1-25)T

v. Prenatal vitamins for pregnant or lactating individuals; and (7-1-25)T

vi. Prescription folic acid and oral prescription drugs containing folic acid in combination with vitamin B12 or iron salts, or both, without additional ingredients. (7-1-25)T

c. Certain prescribed non-prescription products, including the following: (7-1-25)T

i. Permethrin; (7-1-25)T

ii. Oral iron salts; (7-1-25)T

iii. Disposable insulin syringes and needles; and (7-1-25)T

iv. Insulin. (7-1-25)T

d. Barbiturates. (7-1-25)T

e. Benzodiazepines. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Agents, when used for the symptomatic relief of cough and colds. (7-1-25)T

b. Agents, when used for the treatment of obesity. (7-1-25)T

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. (7-1-25)T

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). (7-1-25)T

06. Additional Excluded Drugs. Drugs are not covered when ineligible for federal financial participation. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

b. Contraceptive products may be dispensed in a quantity sufficient for up to six (6) months. (7-1-25)T

213. PRESCRIPTION DRUGS: PROCEDURAL REQUIREMENTS.

01. Request for PA. (7-1-25)T

a. PA is initiated by the prescriber by submitting the request to the Department in the prescribed format. (7-1-25)T

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. (7-1-25)T

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). (7-1-25)T

03. Supplemental Rebates. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

04. Dispensing Procedures. The following protocol is required for prescription filling: (7-1-25)T

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. (7-1-25)T

b. Prescriptions must be maintained on file in pharmacies and available for immediate review by the Department upon written request. (7-1-25)T

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. (7-1-25)T

214. PRESCRIPTION DRUGS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Enrollment. Pharmacies will enroll with the Department using the specific location where the service was performed. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Pharmacy Reimbursement. Prescriptions not filled according to dispensing procedures will be subject to nonpayment or recoupment. The following protocol is required for reimbursement. (7-1-25)T

a. Reimbursement is limited to the lowest of the following: (7-1-25)T

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; (7-1-25)T

ii. State Maximum Allowable Cost (SMAC), as established by the Department, plus professional dispensing fee; (7-1-25)T

iii. Federal Upper Limit (FUL), as established by CMS, plus professional dispensing fee; or (7-1-25)T

iv. The provider's usual and customary charge to the general public. (7-1-25)T

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. (7-1-25)T

c. Provider Administered Drugs. (7-1-25)T

i. Reimbursement to providers that are not 340B-covered entities for medications administered to participants by providers will be: (7-1-25)T

(1) Ninety percent (90%) of the published Medicare Average Sales Price plus six percent (6%) rate (ASP+6% rate). (7-1-25)T

(2) If the ASP+6% rate is not available, payment will be at the WAC. (7-1-25)T

(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. (7-1-25)T

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. (7-1-25)T

d. Clotting Factors. (7-1-25)T

i. Reimbursement to specialty pharmacies will be at a state-based price equivalent to the published Medicare ASP+6% rate, plus professional dispensing fee. (7-1-25)T

ii. Reimbursement to Hemophilia Treatment Centers will be the 340B AAC, not to exceed the 340B ceiling price. (7-1-25)T

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: (7-1-25)T

i. Verifying a participant's coverage; (7-1-25)T

ii. Performing drug use reviews and preferred drug list review activities; (7-1-25)T

iii. Measuring or mixing the covered outpatient drug; (7-1-25)T

iv. Filling the container; (7-1-25)T

v. Participant counseling; (7-1-25)T

vi. Physically providing the completed prescription to the participant; (7-1-25)T

vii. Special packaging; and (7-1-25)T

viii. Overhead associated with maintaining the facility and equipment necessary to operate the dispensing entity. (7-1-25)T

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: (7-1-25)T

i. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (7-1-25)T

ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (7-1-25)T

iii. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (7-1-25)T

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (7-1-25)T

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. (7-1-25)T

02. 340B-Covered Entity Reimbursement. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

b. Drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies are not covered. (7-1-25)T

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. (7-1-25)T

03. Reimbursement for Drugs Dispensed by Other Provider Types. (7-1-25)T

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. (7-1-25)T

b. Drugs acquired via the Federal Supply Schedule (FSS) will be reimbursed at the FSS AAC, plus professional dispensing fee. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

04. Limitations on Payment. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

05. Cost Appeal Process. Cost appeals will be determined by the Department's process provided online. (7-1-25)T

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. (7-1-25)T

02. Hysterectomies. Payment can be made for a hysterectomy only if: (7-1-25)T

a. The participant was advised orally and in writing that sterility would result in the inability to bear children; and (7-1-25)T

ARCHIVE

b. The participant signs and dates a form that meets the requirements of the Idaho Medicaid Provider Handbook. (7-1-25)T

c. Claims require supporting documentation attached to the claim. (7-1-25)T

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. (7-1-25)T

01. Contraceptive Supplies. (7-1-25)T

a. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. (7-1-25)T

b. Payment for oral contraceptives is limited to purchase of a six (6) month supply. (7-1-25)T

02. Sterilization. (7-1-25)T

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. (7-1-25)T

b. Hysterectomies are subject to these rules. (7-1-25)T

c. All requirements of state or local law for obtaining consent, except for spousal consent, must be followed. (7-1-25)T

03. Exceptions to Sterilization Time Requirements. If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the participant's signature on the consent form; and (7-1-25)T

a. In the case of premature delivery, the provider must also state the expected date of delivery and describe the emergency in detail; and (7-1-25)T

b. Describe, in writing to the Department, the nature of any emergency necessitating emergency abdominal surgery; and (7-1-25)T

c. Under no circumstance can the period between consent and sterilization exceed one hundred eighty (180) days. (7-1-25)T

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: (7-1-25)T

a. Certify that all requirements have been met concerning sterilizations; and (7-1-25)T

b. Submit a copy of the court order together with the "Consent Form" and claim. (7-1-25)T

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. (7-1-25)T

224. (RESERVED)

225. FAMILY PLANNING SERVICES: PROVIDER REIMBURSEMENT.
Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Authorization. The managed care contractor is responsible for authorization of covered behavioral health services that require PA. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Any setting in which Medicaid covers inpatient services, including room and board; or (7-1-25)T

b. ICF/IID, unless such services are not otherwise required to be provided by the ICF/IID. (7-1-25)T

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. (7-1-25)T

04. Requirements. Services and items, when appropriate, will meet the requirements for: (7-1-25)T

a. Audiology services under these rules; (7-1-25)T

b. Medical supplies, items, and appliances under these rules; (7-1-25)T

c. Physical therapy, occupational therapy, and speech-language pathology services under these rules; and (7-1-25)T

d. Early Periodic, Screening, Diagnosis, and Treatment Services under these rules. (7-1-25)T

243. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Orders. (7-1-25)T

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. (7-1-25)T

b. Home health services must be reordered at least every sixty (60) days for services and annually for medical supplies, equipment, and appliances. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

b. Payment by the Department for home health will include mileage as part of the visit. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Medical Supplies, Equipment, and Appliances. Payment uses general procedures. (7-1-25)T

247. – 249. (RESERVED)

SUB AREA: THERAPY SERVICES
(Sections 250-259)

250. THERAPY SERVICES: DEFINITIONS.

01. Duplicate Services. Services are considered duplicate: (7-1-25)T

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 (7-1-25)T

b. When more than one (1) type of therapy is provided at the same time. (7-1-25)T

02. Feeding Therapy. Services necessary for the treatment of feeding disorders. (7-1-25)T

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. (7-1-25)T

04. Occupational Therapy Services. Therapy services that: (7-1-25)T

a. Are necessary for the evaluation and treatment of impairments, functional disabilities, or changes in physical function and health status; and (7-1-25)T

b. Improve the ability to perform tasks required for independent functioning. (7-1-25)T

05. Physical Therapy Services. Therapy services that: (7-1-25)T

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 (7-1-25)T

b. Focus on the rehabilitation and prevention of neuromuscular, musculoskeletal, integumentary, and cardiopulmonary disabilities. (7-1-25)T

06. Speech-Language Pathology Services. Therapy services that are: (7-1-25)T

a. Necessary for the evaluation and treatment of speech and language disorders that result in communication disabilities; or (7-1-25)T

b. Necessary for the evaluation and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (7-1-25)T

IAC ARCHIVE 2025

07. Therapeutic Procedures. Therapeutic procedures are the application of clinical skills, services, or both, that attempt to improve function. (7-1-25)T

08. Therapist. An individual licensed by the appropriate state licensing board as an occupational therapist, physical therapist, or speech-language pathologist. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Therapy Services. Services described in the Idaho Medicaid Provider Handbook are covered with the following limitations: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Non-Covered Therapy Services. (7-1-25)T

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement or meet the criteria for a maintenance program. (7-1-25)T

b. Services for developmentally acceptable error patterns. (7-1-25)T

c. Services that do not require the skills of a therapy professional. (7-1-25)T

d. Massage, work hardening, and conditioning. (7-1-25)T

e. Biofeedback, unless provided to treat urinary incontinence. (7-1-25)T

03. Service Limitations. (7-1-25)T

a. Therapy provided through school-based services, or the Idaho Infant Toddler Program is not included in the service limitations under this subsection. (7-1-25)T

b. Maintenance therapy is covered when an individualized assessment demonstrates that skilled care is required to carry out a safe and effective maintenance program. (7-1-25)T

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. (7-1-25)T

01. Orders. (7-1-25)T

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. (7-1-25)T

b. Therapy services provided under home health must comply with the order requirements in home health instead. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

b. The plan of care must be consistent with the therapy evaluation and contain: (7-1-25)T

i. Diagnoses; (7-1-25)T

ii. Treatment goals that are measurable and pertain to the identified functional impairment(s); and (7-1-25)T

iii. Type, frequency, and duration of therapy services. (7-1-25)T

c. Therapy services provided under home health must comply with the home health plan of care requirements. (7-1-25)T

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: (7-1-25)T

01. Home Health Agencies. A per visit rate. (7-1-25)T

02. Independent Therapists. Fee-for-service. A therapy assistant cannot bill Medicaid directly. (7-1-25)T

03. Hospital Services. A rate not to exceed the payment determined as reasonable cost using Medicare standards and principles. (7-1-25)T

04. Long-term Care Facilities. Bundled into the facility reimbursement for participants. (7-1-25)T

05. School-based Services. As per its subsection. (7-1-25)T

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. (7-1-25)T

02. Documentation. The following documentation must be maintained in the files of the provider:

(7-1-25)T

a. Provider orders for therapy services; (7-1-25)T

b. Therapy plans of care; and (7-1-25)T

c. Progress or other notes documenting each assessment, therapy session, and results of tests and measurements related to therapy services. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

263. AUDIOLOGY SERVICES: PROCEDURAL REQUIREMENTS.

01. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedance testing must be ordered in writing. (7-1-25)T

02. Provider Documentation Requirements. Documentation of the following must be kept on file by the provider: (7-1-25)T

a. The participant's diagnosis; (7-1-25)T

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 (7-1-25)T

c. The brand name and model type of the hearing aid with warranty and insurance information. (7-1-25)T

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. (7-1-25)T

IAC ARCHIVE 2025

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. (7-1-25)T

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 Centers for Medicare and Medicaid Services (CMS) in the CMS/Medicare DME coverage manual. Exceptions are described in the Idaho Medicaid Provider Handbook. (7-1-25)T

01. Supply Coverage. The Department will purchase no more than three (3) months of necessary medical supplies in a three (3) month period. (7-1-25)T

02. New Equipment. All equipment must be new at the time of purchase, or for capped rentals, at the time of dispensing. (7-1-25)T

03. Custom Fitting. All prosthetic and orthotic devices that require fitting must be provided by a qualified provider. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

08. Electronically Powered or Enhanced Prosthetic or Orthotics. These items are non-covered. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

273. DMEPOS: PROCEDURAL REQUIREMENTS.

01. Orders. (7-1-25)T

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: (7-1-25)T

i. The medical diagnosis requiring the use of the item; and (7-1-25)T

ii. How long the item will be necessary and frequency of use, and for pro re nata (PRN) orders the conditions for use. (7-1-25)T

b. Medical equipment and supplies must be reordered at least annually. (7-1-25)T

c. Not more than ninety (90) days may elapse between the order date and date of a PA request. (7-1-25)T

02. Rental Procedures. When specified by the Department, equipment must be rented. (7-1-25)T

a. Rental payments, including intermittent payments, are applied to the purchase of the equipment. (7-1-25)T

b. The Department may choose to rent equipment without purchasing it. (7-1-25)T

c. The monthly rental payment will be one-tenth (1/10) of the purchase price. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. An ultra-light or high-strength lightweight wheelchair must have a lifetime warranty period on the frame and crossbraces; (7-1-25)T

b. All electrical components and new or replacement parts must have a minimum six (6) month warranty period; (7-1-25)T

c. All other DME not specified under this rule must have a minimum one (1) year warranty period; (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Eyeglasses and Contacts. Eyewear is covered when needed for correction of a refractive error. (7-1-25)T

a. Lenses will be covered once every four (4) years except when there is documentation of a major visual change. (7-1-25)T

i. Scratch resistant coating is required for all plastic and polycarbonate lenses. (7-1-25)T

ii. Tinted lenses are restricted to extreme medical conditions defined by the Department. (7-1-25)T

b. Contact lenses will be covered only for: (7-1-25)T

i. A need for correction equal to or greater than plus or minus ten (±10) diopters; or (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

d. Fitting fees are covered only when the participant is eligible for the associated supplies. (7-1-25)T

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. (7-1-25)T

04. Non-Covered Items. Trifocal lenses, Progressive lenses, and photo gray. (7-1-25)T

05. Participant Responsibility. Participants are responsible for replacement of broken, lost, or missing glasses. (7-1-25)T

283. – 284. (RESERVED)

285. VISION SERVICES: PROVIDER REIMBURSEMENT.
The Department will designate a supplier to provide all eyeglass frames and lenses. (7-1-25)T

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. (7-1-25)T

291. DENTAL SERVICES: DEFINITIONS.

01. Adults. Participants past the month of their twenty-first birthday. (7-1-25)T

02. Children. Participants from birth through the month of their twenty-first birthday. (7-1-25)T

292. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
All participants are eligible for dental benefits. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Authorization. The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. (7-1-25)T

03. Grievances. The contractor is responsible for tracking and reporting all grievances to the State's contract monitor. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

04. Medicare Cost Report Period. The period of time covered by the Medicare-required annual report of cost. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

301. – 302. (RESERVED)

303. FQHC AND RHC SERVICES: COVERAGE AND LIMITATIONS.
FQHC and RHC services are defined as follows: (7-1-25)T

01. Physician Services. (7-1-25)T

02. Physician Assistant Services. (7-1-25)T

03. Nurse Practitioner or Clinical Nurse Specialist Services. (7-1-25)T

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. (7-1-25)T

05. Chiropractor Services. (7-1-25)T

06. Podiatrist Services. (7-1-25)T

07. Clinical Psychologist Services. (7-1-25)T

08. Licensed Social Worker Services. (7-1-25)T

09. Licensed Clinical Social Worker Services. (7-1-25)T

10. Licensed Masters Social Worker Services. (7-1-25)T

11. Licensed Professional Counselor Services. (7-1-25)T

12. Licensed Clinical Professional Counselor Services. (7-1-25)T

13. Licensed Marriage and Family Therapist Services. (7-1-25)T

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). (7-1-25)T

15. Licensed Dentist and Dental Hygienist Services. (7-1-25)T

16. Pharmacist Services. (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

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). (7-1-25)T

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. (7-1-25)T

a. Reimbursement for services is limited to one (1) encounter per discipline per participant per day. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

307. FQHC AND RHC: RATE SETTING METHODOLOGY.

01. Prospective Payment System. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. New Providers to Idaho Medicaid. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Change in an Encounter Rate Due to a Change in Scope of Services. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Third-Party Liability Not Applicable. (7-1-25)T

316. – 319. (RESERVED)

320. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Individual Educational Plan (IEP). (7-1-25)T

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). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Parental Consent. A one-time parental consent to access public benefits or insurance from a parent or legal guardian for Medicaid reimbursement. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

i. Vocational or educational; (7-1-25)T

ii. Financial; (7-1-25)T

iii. Social relationships or support; (7-1-25)T

iv. Family; (7-1-25)T

v. Basic living skills; (7-1-25)T

vi. Housing; (7-1-25)T

vii. Community or legal; or (7-1-25)T

viii. Health or medical. (7-1-25)T

02. CHIS. Students are eligible to receive CHIS services in accordance with EPSDT, and behavioral consultation of these rules. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Excluded Services. (7-1-25)T

a. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. (7-1-25)T

b. Services provided more than thirty (30) days prior to the signed and dated recommendation or referral. (7-1-25)T

02. Evaluation and Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (7-1-25)T

a. Be conducted by providers for the respective SBS discipline; (7-1-25)T

b. Be directed toward a diagnosis; (7-1-25)T

c. Include recommended interventions to address each need; and (7-1-25)T

d. Include name, title, and signature of the person conducting the evaluation. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

i. Group services provided by one (1) qualified staff providing direct services for two (2) or three (3) students. (7-1-25)T

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). (7-1-25)T

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (7-1-25)T

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. (7-1-25)T

i. Behavioral consultation cannot be provided as a direct intervention service. (7-1-25)T

ii. Behavioral consultation must be limited to thirty-six (36) hours per year. (7-1-25)T

c. Crisis intervention as defined for CHIS services. This service is provided on a short-term basis, typically not exceeding thirty (30) school days. (7-1-25)T

d. Habilitative skill building as defined for CHIS services. (7-1-25)T

e. Interdisciplinary training as defined for CHIS services. (7-1-25)T

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. (7-1-25)T

g. Nursing services including emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. (7-1-25)T

h. Occupational Therapy. (7-1-25)T

i. Personal Care Services (PCS). 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: (7-1-25)T

i. Basic personal care and grooming to include bathing, hair care, assistance with clothing, and basic skin care; (7-1-25)T

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; (7-1-25)T

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (7-1-25)T

iv. Assisting the student with provider-ordered medications that are ordinarily self-administered, under IDAPA 24.34.01; (7-1-25)T

v. Non-nasogastric gastrostomy tube feedings meeting the requirements under personal care services. (7-1-25)T

j. Physical Therapy. (7-1-25)T

k. Psychological Evaluation. (7-1-25)T

l. Psychotherapy. (7-1-25)T

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. (7-1-25)T

n. Speech/Audiological Therapy and Evaluation. (7-1-25)T

o. Social History and Evaluation. (7-1-25)T

p. Transportation Services. Providers can receive reimbursement for mileage for transporting a student between home and school when: (7-1-25)T

i. The student requires special transportation assistance, a wheelchair lift or an attendant, when medically necessary; (7-1-25)T

ii. The vehicle is specifically adapted to meet the needs of a disability; (7-1-25)T

iii. The student receives Medicaid-reimbursable services billed by the provider, other than transportation, on the day transportation is provided; (7-1-25)T

iv. The transportation is included on the student's plan; and (7-1-25)T

v. The mileage, as well as the services performed by the attendant, are documented. (7-1-25)T

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: (7-1-25)T

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

service provided. (7-1-25)T

ii. Included on the student's plan; and (7-1-25)T

iii. Provided by a professional or paraprofessional unable to communicate in the student's primary language. (7-1-25)T

324. SBS: PROCEDURAL REQUIREMENTS.
Documentation requirements: (7-1-25)T

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: (7-1-25)T

a. Type, frequency, and duration of the service provided; (7-1-25)T

b. Title of the provider, including the direct care staff delivering services under the supervision of the professional; (7-1-25)T

c. Measurable goals, when goals are required for the service; and (7-1-25)T

d. Specific place of service, if provided in a location other than school. (7-1-25)T

02. Evaluations and Assessments. (7-1-25)T

03. Service Detail Reports. A service detail report that includes: (7-1-25)T

a. Name of student; (7-1-25)T

b. Name, title, and signature of the person providing the service; (7-1-25)T

c. Date, time, and duration of service; (7-1-25)T

d. Place of service, if provided in a location other than school; (7-1-25)T

e. Category of service and brief description of the specific areas addressed; and (7-1-25)T

f. Student’s response to the service when required for the service. (7-1-25)T

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. (7-1-25)T

05. Documentation of Qualifications of Providers. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

b. Documentation that parents or guardian were provided with a current copy of the child's plan and any pertinent addenda. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

325. SBS: PROVIDER QUALIFICATIONS AND DUTIES.
Qualifications for covered services include licensure and acting within the scope of practice, where applicable. (7-1-25)T

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: (7-1-25)T

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: (7-1-25)T

i. Be at least eighteen (18) years of age; (7-1-25)T

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; (7-1-25)T

iii. Meet the paraprofessional requirements under IDAPA 08.02.02. (7-1-25)T

b. Intervention Technician. As defined for CHIS services but does not need to be the employee of a DDA. (7-1-25)T

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: (7-1-25)T

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; (7-1-25)T

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 (7-1-25)T

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: (7-1-25)T

(1) A Department-approved competency checklist referenced in the Idaho Medicaid Provider Handbook; (7-1-25)T

(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 (7-1-25)T

(3) Other Department-approved competencies as defined in the Idaho Medicaid Provider Handbook. (7-1-25)T

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. (7-1-25)T

e. Evidence-Based Model (EBM) Intervention Paraprofessional. As defined for CHIS services. (7-1-25)T

f. Evidence Based Model (EBM) Intervention Specialist. As defined for CHIS services. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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; (7-1-25)T

b. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, excluding an RN or audiologist; (7-1-25)T

c. An occupational therapist; (7-1-25)T

d. An intervention professional; or (7-1-25)T

e. An EBM intervention professional. (7-1-25)T

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: (7-1-25)T

a. An intervention paraprofessional; (7-1-25)T

b. An intervention technician; (7-1-25)T

c. An intervention specialist; (7-1-25)T

d. An intervention professional; (7-1-25)T

e. An EBM intervention paraprofessional; (7-1-25)T

f. An EBM intervention specialist; (7-1-25)T

g. An EBM intervention professional; (7-1-25)T

h. A licensed physician, licensed practitioner of the healing arts; (7-1-25)T

i. An advanced practice registered nurse; (7-1-25)T

j. A licensed psychologist; (7-1-25)T

k. A licensed clinical professional counselor or professional counselor; (7-1-25)T

l. A licensed marriage and family therapist; (7-1-25)T

m. A licensed Masters social worker, licensed clinical social worker, or licensed social worker; (7-1-25)T

n. A psychologist extender; (7-1-25)T

o. An RN; (7-1-25)T

p. A licensed occupational therapist; or (7-1-25)T

q. An endorsed or certified school psychologist. (7-1-25)T

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: (7-1-25)T

a. An intervention paraprofessional; (7-1-25)T

b. An intervention technician; (7-1-25)T

c. An intervention specialist; (7-1-25)T

d. An intervention professional; (7-1-25)T

e. An EBM intervention paraprofessional; (7-1-25)T

f. An EBM intervention specialist; or (7-1-25)T

g. An EBM intervention professional. (7-1-25)T

05. Interdisciplinary Training. Must be provided by one (1) of the following under behavioral intervention: (7-1-25)T

a. An intervention specialist; (7-1-25)T

b. An intervention professional; (7-1-25)T

c. An EBM intervention specialist; (7-1-25)T

d. An EBM intervention professional. (7-1-25)T

06. Medical Equipment and Supplies. (7-1-25)T

07. Nursing Services. (7-1-25)T

08. Occupational Therapy and Evaluation. Therapy rules apply. (7-1-25)T

09. Personal Care Services (PCS). Must be provided by or under the direction of an RN. (7-1-25)T

a. Providers of PCS must have at least one (1) of the following qualifications: (7-1-25)T

i. Licensed Registered Nurse (RN). (7-1-25)T

ii. Licensed Practical Nurse (LPN). (7-1-25)T

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iii. Certified Nursing Assistant (CNA). (7-1-25)T

iv. Personal Assistant. A person with training to ensure the quality of services who is at least eighteen (18) years of age. (7-1-25)T

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: (7-1-25)T

i. Development of the written PCS plan of care; (7-1-25)T

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 (7-1-25)T

iii. Reevaluation of the plan of care as necessary, but at least annually. (7-1-25)T

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. (7-1-25)T

10. Physical Therapy and Evaluation. Therapy rules apply. (7-1-25)T

11. Psychological Evaluation. (7-1-25)T

12. Psychotherapy. (7-1-25)T

13. Skills Building/Community-Based Rehabilitation Services (CBRS). Skills Building/CBRS must be provided by one (1) of the following: (7-1-25)T

a. Licensed physician, licensed practitioner of the healing arts; (7-1-25)T

b. Advanced practice registered nurse; (7-1-25)T

c. Licensed psychologist; (7-1-25)T

d. Licensed clinical professional counselor or professional counselor; (7-1-25)T

e. Licensed marriage and family therapist; (7-1-25)T

f. Licensed master's social worker, licensed clinical social worker, or licensed social worker; (7-1-25)T

g. Psychologist extender registered with the Division of Occupational and professional Licenses; (7-1-25)T

h. Licensed registered nurse (RN); (7-1-25)T

i. Licensed occupational therapist; (7-1-25)T

j. Endorsed or certified school psychologist; (7-1-25)T

k. Skills Building/Community Based Rehabilitation Services specialist who must: (7-1-25)T

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 (7-1-25)T

ii. Have a credential required for CBRS specialists. (7-1-25)T

14. Speech/Audiological Therapy. Therapy rules apply. (7-1-25)T

15. Social History and Evaluation. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

326. SBS: PROVIDER REIMBURSEMENT.
Only school districts and charter schools can be reimbursed for SBS. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. (7-1-25)T

b. Providers will send the Department the matching funds, either by check or automated clearing house (ACH) electronic funds transfers. (7-1-25)T

c. The Department will hold matching funds in an interest-bearing trust account. The average daily balance during a month must exceed one hundred dollars ($100) in order to receive interest for that month. (7-1-25)T

d. The payments to the districts will include both the federal and non-federal share (matching funds). (7-1-25)T

e. Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. (7-1-25)T

f. If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed, and reimbursement will be made during the next payment cycle. (7-1-25)T

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. (7-1-25)T

h. The school districts will estimate the amount of their next billing, and the amount of matching funds needed to pay the Department. (7-1-25)T

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: (7-1-25)T

a. The point of pickup is inaccessible by land vehicle; or (7-1-25)T

b. Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential; and (7-1-25)T

c. Air ambulance service will be covered where the participant's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Air Ambulance. Air ambulance services must be approved in advance by the Department, except in emergency situations. Emergency air ambulance services will be authorized by the Department on a retrospective basis. (7-1-25)T

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. (7-1-25)T

02. Air Ambulance. The operator of the air service must bill the Department directly. (7-1-25)T

335. EMERGENCY TRANSPORTATION SERVICES: PROVIDER REIMBURSEMENT.

Payment for ambulance services is subject to the following: (7-1-25)T

01. Ambulance Reimbursement Base Rate. (7-1-25)T

a. The base rate for ambulance services includes customary patient care equipment and items such as stretchers, clean linens, reusable devices and equipment. The base rate also includes nonreusable items, and disposable supplies such as oxygen, triangular bandages and dressings that may be required for the care of the participant during transport. In addition to the base rate, the Department will reimburse mileage. (7-1-25)T

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: (7-1-25)T

i. The level of personnel required to be in the patient compartment of the ambulance; (7-1-25)T

ii. The level of ambulance license the unit has been issued; and (7-1-25)T

iii. The level of life support authorized by the Department. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

d. If multiple licensed EMS providers transport a participant for different legs of a trip, each provider must bill their base rate and mileage. (7-1-25)T

e. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department. (7-1-25)T

f. If a physician is in attendance during transport, they are responsible for the billing of their services. (7-1-25)T

03. Round Trips and Standby. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. NEMT. NEMT is transportation that is: (7-1-25)T

a. Not of an emergency nature; and (7-1-25)T

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. (7-1-25)T

03. Transportation Broker. An entity under contract with the Department to administer, coordinate, and manage a statewide network of NEMT providers. (7-1-25)T

04. Travel-Related Services. Travel-related services are meals, lodging, and attendant care required for NEMT to be completed for a Medicaid participant. (7-1-25)T

341. NEMT SERVICES: DUTIES OF THE TRANSPORTATION BROKER.
The transportation broker under contract with the Department is required to: (7-1-25)T

01. Coordinate and Manage. Coordinate and manage all NEMT services for Medicaid participants statewide. (7-1-25)T

02. Contract With Transportation Providers. Contract with transportation providers throughout the state to provide NEMT services for Medicaid participants. (7-1-25)T

03. Call Center. Operate a call center to receive and review NEMT for Medicaid participants meeting NEMT requirements. (7-1-25)T

04. Authorize NEMT Services. Authorize NEMT services for Medicaid participants requesting transportation and who meet NEMT requirements. (7-1-25)T

05. Reimburse Contracted Transportation Providers. Reimburse contracted transportation providers for NEMT services meeting the NEMT requirements. (7-1-25)T

06. Safe and Professional Transportation. Assure that contracted transportation providers deliver NEMT services in a safe and professional manner. (7-1-25)T

342. NEMT SERVICES: COVERAGE AND LIMITATIONS.

01. NEMT Services. The transportation broker will reimburse contracted transportation providers for NEMT services under the following conditions: (7-1-25)T

a. The travel is essential to get to or from a covered service; (7-1-25)T

b. The mode of transportation is the least costly that is appropriate for the medical needs of the participant; (7-1-25)T

c. The transportation is to the nearest medical provider appropriate to perform the needed services, and transportation is by the most direct route practicable; (7-1-25)T

d. Other modes of transportation, including personal vehicle, assistance by family, friends, and charitable organizations, are unavailable or impractical under the circumstances; (7-1-25)T

e. The travel is authorized and scheduled by the transportation broker; and (7-1-25)T

f. The contracted transportation provider follows the terms of its contract with the transportation broker. (7-1-25)T

02. Travel-Related Services. The transportation broker will reimburse a contracted transportation provider for travel-related services under the following circumstances: (7-1-25)T

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. (7-1-25)T

b. The reasonable cost for lodging actually incurred for the participant will be reimbursed when: (7-1-25)T

i. The round trip and the needed medical service cannot be completed in the same day; and (7-1-25)T

ii. No less costly alternative is available. (7-1-25)T

c. The reasonable cost of wages for a non-family member attendant will be reimbursed when: (7-1-25)T

i. An attendant is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and (7-1-25)T

ii. No other unpaid attendant is available to accompany the participant. (7-1-25)T

d. The reasonable cost of meals actually incurred in transit will be reimbursed for one (1) family member or one (1) attendant, when: (7-1-25)T

i. Attendant care is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and (7-1-25)T

ii. There is no other practical means of obtaining food. (7-1-25)T

e. The reasonable cost of lodging actually incurred will be reimbursed for one (1) family member or one (1) attendant when: (7-1-25)T

i. An overnight stay is required to receive the service; (7-1-25)T

ii. It is medically necessary, or the vulnerability of the participant requires accompaniment for safety; and (7-1-25)T

iii. No less costly alternative is available. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Periodic Medical Screens. Screens done per the American Academy of Pediatrics periodicity schedule. (7-1-25)T

351. EPSDT SERVICES: PARTICIPANT ELIGIBILITY.
EPSDT services are available to participants from birth through the month of their twenty-first birthday. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Eyeglasses Under EPSDT. (7-1-25)T

a. In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change. (7-1-25)T

b. The Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one (1) of these reasons on their claim. If repair costs are greater than the cost of new frames, new frames may be authorized. (7-1-25)T

353. (RESERVED)

354. EPSDT SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Interperiodic and periodic medical screens must be performed by a physician, NP, or Physicians Assistant. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Individual and Family Social Services. Limited to two (2) visits during the covered period. (7-1-25)T

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. (7-1-25)T

03. Nursing Services. Limited to two (2) visits during the covered period. (7-1-25)T

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. (7-1-25)T

05. Risk Reduction Follow-Up. (7-1-25)T

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. (7-1-25)T

02. Individual and Family Social Services. A licensed social worker qualified to provide individual counseling. (7-1-25)T

365. PREGNANCY-RELATED SERVICES: PROVIDER REIMBURSEMENT.
A single payment will be made for each month of risk reduction follow-up services provided. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. PDN RN Supervisor. An RN providing oversight of PDN delegated to LPNs providing a child's care. (7-1-25)T

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). (7-1-25)T

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. (7-1-25)T

01. Provider Ordered. (7-1-25)T

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 (7-1-25)T

b. A determination of total PDN hours needed to ensure a child's health and safety in their home. (7-1-25)T

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. (7-1-25)T

03. Service Plan. (7-1-25)T

a. Developed by a multi-disciplinary team including the parent or legal guardian, the primary RN, or RN Supervisor, and a Department representative; (7-1-25)T

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; (7-1-25)T

c. Approved and signed by an attending provider, parent or legal guardian, the primary RN or RN supervisor, and a Department representative; and (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. RN Responsibilities. RN supervisors or a provider of PDN must: (7-1-25)T

a. Notify the physician immediately of any significant changes in a child's medical condition or response to PDN; (7-1-25)T

b. Notify the Department within forty-eight (48) hours or on the first business day following a

weekend or holiday of any significant changes in a child's condition or a child is hospitalized at any time; (7-1-25)T

c. Evaluate changes of condition; (7-1-25)T

d. Provide PDN under the PDN service plan; and (7-1-25)T

e. Ensure copies of records are maintained in the child's home including: (7-1-25)T

i. Service delivery date and start and end times; (7-1-25)T

ii Comments on the child's response to PDN; (7-1-25)T

iii. Nursing assessment of child's status and any changes in status each shift; (7-1-25)T

iv. Services provided during each shift; and (7-1-25)T

v. Current signed Service Plan. (7-1-25)T

04. Oversight of LPNs. RN Supervisory visits occur at least once every thirty (30) days for PDN provided by an LPN. (7-1-25)T

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). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Adult LOC. The Department uses a standard assessment to determine adults meet one (1) of the Resource Utilization Group (RUG III) classifications. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

ii. The child's condition requires skilled care to sustain current capacities, regardless of their restoration potential, even when improvement is not possible. (7-1-25)T

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. (7-1-25)T

472. NF: PATIENT LIABILITY.
The Department reduces payment to the NF by each participant's patient liability as determined during the financial

eligibility process. (7-1-25)T

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. (7-1-25)T

01. Minimum Coverage. Minimum services and supplies include: (7-1-25)T

a. Room and board; (7-1-25)T

b. Bed and bathroom linens; (7-1-25)T

c. Nursing care, including special feeding if needed; (7-1-25)T

d. Personal services; (7-1-25)T

e. Supervision when required by the patient's condition; (7-1-25)T

f. Special diets prescribed by a physician; (7-1-25)T

g. All common over-the counter medicine chest supplies; (7-1-25)T

h. Dressings. Applications using prescription medications or aseptic techniques must be completed by an RN; (7-1-25)T

i. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (7-1-25)T

j. Application or administration of all drugs; (7-1-25)T

k. All common disposable medical supplies; (7-1-25)T

l. Social and recreational activities; and (7-1-25)T

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. (7-1-25)T

02. Skilled Services. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Limitations. (7-1-25)T

a. Services requiring skilled nursing staff include: (7-1-25)T

i. Intravenous injections or feedings and intramuscular or subcutaneous injections required on more than one (1) shift; (7-1-25)T

IAC ARCHIVE 2025

ii. Nasopharyngeal feedings and aspiration; (7-1-25)T

iii. Tracheotomy aspiration; (7-1-25)T

iv. Catheter insertion, sterile irrigation, and replacement; (7-1-25)T

v. Treating extensive decubitus ulcers or other widespread skin disorders; (7-1-25)T

vi. Heat treatments specifically ordered by a physician as part of treatment and requiring nurse observation to adequately evaluate a resident's progress; and (7-1-25)T

vii. Initial phases of a regimen involving oxygen administration. (7-1-25)T

b. Services requiring physical or occupational therapists include: (7-1-25)T

i. Therapeutic exercises or activities must be performed by or under supervision to ensure resident safety and treatment effectiveness; (7-1-25)T

ii. Gait evaluation and training to restore function in a resident whose ability to walk is impaired by neurological, muscular, or skeletal abnormality; (7-1-25)T

iii. Ultrasound, short-wave, and microwave therapy treatments; and (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

01. Change of Status. Any participant readmission, discharge, or any temporary absence due to hospitalization or therapeutic home visit. (7-1-25)T

02. Changes of Resident's Income. (7-1-25)T

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. (7-1-25)T

04. Other Patient Financial Information. Other information about a resident's finances that potentially affects eligibility for Medicaid. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Specialized Services. Needs must be documented and included in both the resident assessment and service plan. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Licensure and Certification (L&C). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

c. The Department certifies to the appropriate branch of government when the State determines a NF meets certification standards for NF care. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

486. NF: DISTRESSED FACILITY.

01. Department Determination. NFs in an under-served area, or addressing an under-served need, may receive an alternative rate. (7-1-25)T

02. Discretionary Factors. A NF is not guaranteed increased payment. The Department considers factors for a higher rate on a NF-by-NF basis: (7-1-25)T

a. Prudent spending patterns and cost allocation as evidenced by a Department review of the NF's accounts. (7-1-25)T

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. (7-1-25)T

c. The same costs of care used to determine special rates are not applied toward a determination of distressed facility status. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Annual Review. Distressed facility payments are short-term and redetermined for each fiscal year a NF requests a distressed facility rate. (7-1-25)T

04. Prospective Application. Only NFs currently distressed or entering a period of distress are eligible. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

489. NF: BCU QUALIFICATIONS.
Facilities must meet the qualifications for a BCU described in the Idaho Medicaid Provider Agreement Additional Terms – Behavioral Care Units. (7-1-25)T

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%). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Effective Date. Upon approval, a special rate is effective on the date set by the Department. (7-1-25)T

03. Reporting. Costs equivalent to payments for special rate add-on amounts are removed from cost components subject to limits and reported separately. (7-1-25)T

04. Limitation. Special rates cannot exceed a NF's charges to other patients for similar services. (7-1-25)T

05. Prospective Rate Treatment. Special rates are paid under a prospective payment system. (7-1-25)T

06. Payment for Qualifying Residents. The Department calculates special rate add-on amounts using one (1) of the following methods: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

ii. NFs must inform the Department when an approved add-on rate is no longer needed or a resident's special needs change. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Fixed Costs. Occupancy adjustments to fixed costs are considered allowable and reimbursable costs when reported under property cost categories. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

01. NF Occupancy Limits. Payment for temporary absences from NFs are made according to the number of licensed and unoccupied beds. (7-1-25)T

a. Payments are not allowed for NFs with less than one hundred (100) licensed beds when five (5) or more are unoccupied. (7-1-25)T

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%). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Required Information for Applications. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

e. An initial plan of care developed by the admitting ICF/IID. (7-1-25)T

02. ICF/IID Eligibility Criteria. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

i. Complete medical, social, and psychological evaluations that clearly indicate the functional level of the participant and interventions needed; and (7-1-25)T

ii. A written plan of care with initial goals and objectives, specifying further evaluations required, and training programs to be developed. (7-1-25)T

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. (7-1-25)T

d. ICF/IID level of care is redetermined annually related to continued need of community services. (7-1-25)T

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. (7-1-25)T

ii. Individuals receiving DD waiver services have thirty (30) days from the determination to transition to other community supports. (7-1-25)T

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. (7-1-25)T

01. Coverage. The minimum content of care and services for ICF/IID residents includes: (7-1-25)T

a. Room and board; (7-1-25)T

b. Bed and bathroom linens; (7-1-25)T

c. Nursing care, including special feeding if needed; (7-1-25)T

d. Personal services; (7-1-25)T

e. Supervision; (7-1-25)T

f. Special diets as prescribed by a participant's provider; (7-1-25)T

g. All common medicinal supplies that do not require a prescription; (7-1-25)T

h. Dressings; (7-1-25)T

i. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (7-1-25)T

j. Application or administration of all drugs; (7-1-25)T

k. All medical supplies; (7-1-25)T

l. Social and recreational activities; and (7-1-25)T

m. Items used by individuals that are reusable and expected to be available. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Readmissions or discharges, including any participant's temporary absence due to hospitalization or therapeutic home visit. (7-1-25)T

b. Changes to participant's income. (7-1-25)T

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. (7-1-25)T

d. Other changes to participant's finances that may potentially affect their eligibility for Medicaid. (7-1-25)T

02. Annual Recertification. ICF/IIDs must assure that participant annual recertifications are completed. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Sixty-eight and twenty-five hundredths (68.25) hours for a severely and profoundly intellectually disabled resident. (7-1-25)T

b. Fifty-four and six tenths (54.6) hours for a moderately intellectually disabled resident. (7-1-25)T

c. Thirty-four and one hundred twenty-five thousandths (34.125) hours for a mildly intellectually disabled resident. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

506. (RESERVED)

507. ICF/IID: ALLOWABLE COSTS.

01. Auto and Travel Expense. (7-1-25)T

02. Bad Debts. (7-1-25)T

03. Bank or Finance Charges. (7-1-25)T

04. Compensation of Owners. (7-1-25)T

05. Contracted Service. (7-1-25)T

06. Depreciation. (7-1-25)T

07. Dues, Licenses, or Subscriptions. (7-1-25)T

08. Employee Benefits. (7-1-25)T

09. Employee Recruitment. (7-1-25)T

10. Entertainment Costs Related to Patient Care. (7-1-25)T

11. Food. (7-1-25)T

12. Home Office Costs. (7-1-25)T

IAC ARCHIVE 2025

13. Insurance. (7-1-25)T

14. Interest. (7-1-25)T

15. Lease or Rental Payments. (7-1-25)T

16. Malpractice or Public Liability Insurance. (7-1-25)T

17. Payroll Taxes. (7-1-25)T

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. (7-1-25)T

19. Property Costs. (7-1-25)T

20. Property Insurance. (7-1-25)T

21. Repairs or Maintenance. (7-1-25)T

22. Salaries. (7-1-25)T

23. Supplies. (7-1-25)T

24. Taxes. (7-1-25)T

508. ICF/IID: NON-ALLOWABLE COSTS.

01. Accelerated Depreciation. (7-1-25)T

02. Acquisitions. (7-1-25)T

03. Charity Allowances. (7-1-25)T

04. Consultant Fees. (7-1-25)T

05. Franchise Fees. (7-1-25)T

06. Fund Raising. (7-1-25)T

07. Goodwill. (7-1-25)T

08. Holding Companies. (7-1-25)T

09. Interest to Finance Unallowable Costs. (7-1-25)T

10. Medicare Costs. (7-1-25)T

11. Non-patient Care Related Activities. (7-1-25)T

12. Organization. (7-1-25)T

13. Pharmacist Salaries. (7-1-25)T

14. Prescription Drugs. (7-1-25)T

IAC ARCHIVE 2025

15. Related Party Interest. (7-1-25)T

16. Related Party Non-allowable Costs. (7-1-25)T

17. Related Party Refunds. (7-1-25)T

18. Self-Employment Taxes. (7-1-25)T

19. Vending Machines. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Fixed Costs. Occupancy adjustment to fixed costs is considered allowable and reimbursable when reported under property cost categories. (7-1-25)T

04. New Facility. For newly licensed and occupied facilities, the first six (6) months occupancy level is not subject to an adjustment. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

512. ICF/IID: REPORTING SYSTEM.
A uniform system of periodic reports is used to allow: (7-1-25)T

01. Basis for Reimbursement. By approximating actual costs. (7-1-25)T

02. Adequate Financial Disclosure. (7-1-25)T

03. Statistical Resources. As a basis for measuring reasonable costs and comparative analysis. (7-1-25)T

04. Criteria For Evaluating Policies and Procedures. (7-1-25)T

513. ICF/IID: REPORTING SYSTEM PRINCIPLE AND APPLICATION.
Providers must file annual cost reports. (7-1-25)T

01. Cost Report Requirements. The fiscal year end filings include: (7-1-25)T

a. Annual income statement; (7-1-25)T

b. Balance sheet; (7-1-25)T

c. Statement of ownership; (7-1-25)T

d. Schedule of patient days; (7-1-25)T

e. Schedule of private patient charges; (7-1-25)T

f. Statement of additional charges to residents above usual monthly rates; and (7-1-25)T

g. Other schedules, statements, and documents as requested. (7-1-25)T

02. Special Reports. When required, specific instructions are issued, based upon the circumstance. (7-1-25)T

03. Report Criteria. (7-1-25)T

a. Use of State-approved formats. (7-1-25)T

b. Presented on accrual basis. (7-1-25)T

c. Prepared according to GAAP and principles of reimbursement. (7-1-25)T

d. Providing appropriate detail on supporting schedules or as requested. (7-1-25)T

04. Preparer. Statements do not require a CPA. (7-1-25)T

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. (7-1-25)T

06. Change of Management or Ownership. To properly pay separate entities or individuals after a change of management or ownership, the following requirements apply: (7-1-25)T

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. (7-1-25)T

b. The Department may require an appraisal for a change in ownership. (7-1-25)T

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

ARCHIVE

apply. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

01. Straight-Line Depreciation. (7-1-25)T

02. Interest. (7-1-25)T

03. Property Insurance. (7-1-25)T

04. Lease Payments. (7-1-25)T

05. Property Taxes. (7-1-25)T

06. Costs of Related Party Leases. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. The median of the range is computed based on the available data points considered the total population of data points. (7-1-25)T

b. A new cap and rate are set annually for each facility July 1st. (7-1-25)T

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. (7-1-25)T

d. Payment of costs subject to the cap are limited to the cap unless the Department determines the exclusions. (7-1-25)T

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. (7-1-25)T

01. Failure to Meet Conditions. (7-1-25)T

02. First Time Provider. (7-1-25)T

03. New ICF/IID Living Unit. (7-1-25)T

04. Ownership Change. (7-1-25)T

05. Fraudulent Claims. (7-1-25)T

06. Excluded Costs. (7-1-25)T

520. ICF/IID: EXEMPT COSTS.
Day treatment services and major movable equipment costs are not subject to the ICF/IID cap. (7-1-25)T

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: (7-1-25)T

01. Increases to Per Participant Day Costs. (7-1-25)T

02. Excess Inflation. (7-1-25)T

03. Cost Increases Over 3%. (7-1-25)T

04. Decreases. (7-1-25)T

05. Prospective Negotiated Rates. (7-1-25)T

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

ARCHIVE

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. (7-1-25)T

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: (7-1-25)T

a. "R" = "Property Base" x forty (40) - "Age" / forty (40) x "change in building costs" where: (7-1-25)T

b. "R" = the property rental rate. (7-1-25)T

c. "Property Base": (7-1-25)T

i. Eleven dollars and twenty-two cents ($11.22) for ICF/IID with wheelchair accommodations. (7-1-25)T

ii. Seven dollars and twenty-two cents ($7.22) for ICF/IID without wheelchair accommodations. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Facility Sale. When a facility, or asset of a facility, is sold, the buyer receives the property rental rate as calculated. (7-1-25)T

524. ICF/IID: PROPERTY REIMBURSEMENT LIMITATIONS.
Property costs of an ICF/IID are reimbursed except as follows: (7-1-25)T

01. Property Leases. No grandfathered rates or lease provisions other than the following apply: (7-1-25)T

a. Property costs related to living units other than costs for major movable equipment are paid the property rental rate. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

01. New Admissions to a Community ICF/IID. (7-1-25)T

02. Significant Change in Condition. Residents of a community ICF/IID experiencing a significant change in condition not reflected in their current rate. (7-1-25)T

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. (7-1-25)T

04. Emergency. An emergency exists when a facility must incur additional behavioral or medical costs to prevent more restrictive placements. (7-1-25)T

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: (7-1-25)T

01. A&D Waiver Services. (7-1-25)T

02. Consumer-Directed Services. (7-1-25)T

03. DD 1915i and Waiver Services. (7-1-25)T

04. PCS. (7-1-25)T

05. Youth Empowerment Services (YES) for Children with Serious Emotional Disturbance (SED). (7-1-25)T

531. HCBS EXCEPTIONS.
These rules do not supersede decision-making authority legally assigned on the participant's behalf including: (7-1-25)T

01. Payees appointed by the SSA. (7-1-25)T

02. Judicial Restrictions. Court-imposed restrictions due to probation, parole, or for commitments to the Department Director; and (7-1-25)T

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. (7-1-25)T

532. (RESERVED)

533. HCBS: PROVIDER QUALIFICATIONS AND DUTIES.
Providers must develop and implement policies and procedures to address the HCBS setting requirements. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Setting Selection. Identify and document the alternative HCBS options considered by the participant, or the participant's decision-making authority. (7-1-25)T

02. Plan Signatures. The plan must also be signed by the plan developer and all individuals and providers responsible for its implementation. (7-1-25)T

03. Residential Requirements. Any exception to residential provider-owned or controlled setting

qualities must be documented in the person-centered plan. (7-1-25)T

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: (7-1-25)T

a. An independent assessment; (7-1-25)T

b. A state-approved person-centered plan; (7-1-25)T

c. Annual eligibility redetermination; and (7-1-25)T

d. Other state-established criteria for determining Medicaid eligibility. (7-1-25)T

02. Failure to Meet Requirements. A participant who does not meet eligibility criteria is subject to termination of enrollment. (7-1-25)T

03. Conditions for Termination. The Department will terminate participant enrollment if they: (7-1-25)T

a. Do not have an identified need for a waiver or State Plan option service; (7-1-25)T

b. Elect not to use services offered under the HCBS waiver or State Plan option; (7-1-25)T

c. Decline to engage in person-centered planning; (7-1-25)T

d. Do not meet other HCBS eligibility requirements; or (7-1-25)T

e. Are non-responsive to three or more contact attempts by the Department or its designee. (7-1-25)T

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. (7-1-25)T

**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. (7-1-25)T

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). (7-1-25)T

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. (7-1-25)T

541. A&D WAIVER SERVICES: ELIGIBILITY.

IAC ARCHIVE 2025

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: (7-1-25)T

01. **Age**. Are eighteen (18) years of age or older. (7-1-25)T

02. **Disabling Condition**. Have a disabling condition that impairs their mental or physical function or independence; (7-1-25)T

03. **Non-Institutional Setting**. Can be maintained safely and effectively in a non-institutional setting; (7-1-25)T

04. **Require Services**. In the absence of such services, require the level of care provided in a NF; (7-1-25)T

05. **Average Daily Cost**. Cannot exceed the participant's waiver and other medical services for the average daily cost of NF care; (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

08. **NF Level of Care, Adults**. Based on assessment results, the level of impairment of an individual is established by the Department. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Medication assistance, to the extent permitted under State law; (7-1-25)T

b. Assistance with ADL; (7-1-25)T

c. Meals, including special diets; (7-1-25)T

d. Housekeeping; (7-1-25)T

e. Laundry; (7-1-25)T

f. Transportation; (7-1-25)T

g. Opportunities for socialization for participants in a RALF; (7-1-25)T

h. Recreation; and (7-1-25)T

i. Assistance with personal finances. (7-1-25)T

03. Specialized Medical Equipment and Supplies. (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

10. Homemaker 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. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Self-direction; (7-1-25)T

b. Money management; (7-1-25)T

c. Daily living skills; (7-1-25)T

d. Socialization not including participation in non-therapeutic activities that are diversional or recreational in nature; (7-1-25)T

e. Mobility; (7-1-25)T

f. Behavior shaping and management. (7-1-25)T

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. (7-1-25)T

h. Skills training to teach participants and supports to perform activities with greater independence and to reinforce habilitation training. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Services may include: (7-1-25)T

i. Security deposits required to obtain a lease on an apartment or home; (7-1-25)T

ii. Cost of essential household furnishings; (7-1-25)T

iii. Set-up fees or deposits for utility or service access; (7-1-25)T

iv. Services necessary for health and safety prior to occupancy; (7-1-25)T

v. Moving expenses; and (7-1-25)T

vi. Activities to assess need, arrange for, and procure transition services. (7-1-25)T

b. Exclusions. Ongoing expenses (including utilities), real property, décor, or entertainment and recreational items. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Services not in the individual service plan or exceeding those approved by the Department are not eligible for Medicaid payment. (7-1-25)T

b. The earliest services can be approved is on the date an individual service plan is signed by the participant or their designee. (7-1-25)T

c. All services that are provided must be based on a documented service plan. (7-1-25)T

d. A new plan must be developed and approved annually. (7-1-25)T

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. (7-1-25)T

02. Provider Records. (7-1-25)T

a. Providers must document each visit made or service provided to the participant, and record the following: (7-1-25)T

i. Service date; (7-1-25)T

ii. Services provided; (7-1-25)T

iii. Statement of participant's response to services when applicable, including any changes in their condition; and (7-1-25)T

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. (7-1-25)T

b. Providers must maintain service delivery records accessible to participants. (7-1-25)T

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. (7-1-25)T

d. EVV Systems do not replace documentation requirements but may be used to generate documentation. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Fiscal Intermediary Services (FI). An FI providing Consultation services supporting self-direction must: (7-1-25)T

a. Assure compliance with legal requirements related to employment of providers; (7-1-25)T

b. Offer supportive services to enable participants or their families to perform the required employer tasks themselves; (7-1-25)T

c. Bill Medicaid for services authorized by the Department; (7-1-25)T

d. Collect any participant participation due; (7-1-25)T

e. Pay providers for service; (7-1-25)T

f. Perform all necessary withholding as required by state and federal regulations; (7-1-25)T

g. Assure that providers meet the required standards and qualifications; (7-1-25)T

h. Maintain liability insurance coverage; (7-1-25)T

i. Conduct annual participant satisfaction or quality control reviews made available to the Department and the public; and (7-1-25)T

j. Obtain required background checks and health screens on employees. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

07. Adult Residential Care. Must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. (7-1-25)T

08. Home-Delivered Meals. (7-1-25)T

a. Each meal meets one third (1/3) of the Recommended Daily Allowance, as defined by the United States Department of Agriculture (USDA); (7-1-25)T

b. Meals are delivered under the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (7-1-25)T

c. Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; and (7-1-25)T

d. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions. (7-1-25)T

09. PERS. Must demonstrate that devices installed in a participant's home meet Federal Communications Commission (FCC) standards. (7-1-25)T

10. Adult Day Health. (7-1-25)T

a. Providers must notify the Department for the participant when the service is provided in a CFH other than the participant's primary residence. (7-1-25)T

b. Providers must be free from communicable disease. (7-1-25)T

11. Non-Medical Transportation. Possess a valid driver's license and vehicle insurance. (7-1-25)T

12. Attendant Care. Must be employees of an agency. (7-1-25)T

13. Homemaker Services. Must be employees of an agency. (7-1-25)T

14. Environmental Accessibility Adaptations. Must meet applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

17. Respite Care. Receive instructions in the participant's needs, demonstrate the ability to follow the service plan, and be free of communicable disease. (7-1-25)T

18. Supported Employment. Provided by an agency that meets State requirements. (7-1-25)T

19. Chore Services. Be skilled in the service to be provided; and demonstrate the ability to follow a service plan. (7-1-25)T

20. Transition Services. Transition managers. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Electronic Visit Verification (EVV) Compliance. Claims for Attendant Care, Homemaker, and Respite services require EVV compliance to be reimbursable. (7-1-25)T

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. (7-1-25)T

01. Provider Qualifications. Transition managers must: (7-1-25)T

a. Successfully complete of a Department-approved Transition Manager training prior to providing any transition management or transition services; (7-1-25)T

b. Have a Bachelor's degree in a human services field or three (3) years' supervised work experience with the population served; and (7-1-25)T

c. Be employed by an agency. (7-1-25)T

02. Service Description. Includes the following activities: (7-1-25)T

a. A comprehensive assessment of health, social, and housing needs; (7-1-25)T

b. Development of housing options, including assistance with housing choices, applications, waitlist follow-up, roommate selection, and introductory visits; (7-1-25)T

c. Assistance with tasks necessary to accomplish a move from the institutional setting; (7-1-25)T

d. Securing Transition Services to coordinate the move, including: (7-1-25)T

i. Obtaining DME, assistive technology, and medical supplies; (7-1-25)T

ii. Arranging for home modifications; (7-1-25)T

iii. Applying for public assistance; or (7-1-25)T

iv. Arranging household preparations including scheduling moving or cleaning services, utility set-up, purchasing furniture, and household supplies. (7-1-25)T

e. Coordinating with others involved in plan development for the participant to ensure successful transition and establishment in a community setting; and (7-1-25)T

f. Providing post-transition support, including assistance with problem solving, dependency and isolation concerns, consumer-directed services and supports, post-secondary educational institutions and proprietary schools, and community inclusion. (7-1-25)T

03. Limitations. Transition management is limited to seventy-two (72) hours per participant per qualifying transition. (7-1-25)T

SUB AREA: PERSONAL CARE SERVICES (PCS)
(Sections 550-559)

550. PCS: DEFINITIONS.

01. PCS. Medically oriented care services for a participant's physical or functional requirements in the participant's home or personal residence but does not include housekeeping or skilled nursing care. (7-1-25)T

02. PCS Family Alternate Care Home. A private home licensed by the Department to provide PCS to one (1) or two (2) children, who are unable to reside in their own home and require medically oriented tasks related to the child's physical or functional needs. (7-1-25)T

551. PCS: ELIGIBILITY.

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. (7-1-25)T

02. Redetermination. Required annually to reauthorize PCS or to refer a participant to a NF. (7-1-25)T

03. Significant Changes. An assessment can be requested due to changes in a participant's needs at any time. (7-1-25)T

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: (7-1-25)T

a. Basic personal care and grooming; (7-1-25)T

b. Bladder or bowel routines or requirements; (7-1-25)T

c. Food, nutrition, and diet activities; (7-1-25)T

d. Continuation of at home active treatment programs to increase or maintain independence for participants with DD; (7-1-25)T

e. Physician-ordered medications ordinarily self-administered; (7-1-25)T

f. Non-nasogastric gastrostomy tube feedings that meet the following requirements: (7-1-25)T

i. Non-complex tasks that can be safely performed in a participant's location; (7-1-25)T

ii. An RN assessed a participant's needs and developed a written procedure according to a participant's individualized needs; (7-1-25)T

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; (7-1-25)T

iv. Delegates must report any change in participant status or problems with the procedure immediately to the RN; (7-1-25)T

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 (7-1-25)T

vi. Direct care workers only give routine medication through a non-nasogastric tube as authorized by a supervisor RN. (7-1-25)T

02. Non-Medical Care and Services. Includes the following tasks, when no natural supports are available: (7-1-25)T

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. (7-1-25)T

b. Accompanying a participant to medical appointments or other trips reasonably required for medical diagnosis or treatment. (7-1-25)T

c. Shopping for food or other items specific to a participant's health and maintenance. (7-1-25)T

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. (7-1-25)T

04. Service Exclusions. (7-1-25)T

a. Irrigating or suctioning any body cavity requiring sterile procedures or applying dressings with prescription medication or aseptic techniques; (7-1-25)T

b. Catheter insertion or sterile irrigation; (7-1-25)T

c. Injecting fluids into veins, muscles or skin; and (7-1-25)T

d. Administering medication not authorized by a supervisor RN. (7-1-25)T

05. Participant Limitations. Sixteen (16) hours per week unless authorized under EPSDT. (7-1-25)T

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. (7-1-25)T

553. PCS: PROCEDURAL REQUIREMENTS.

01. Service Plan. All PCS are provided based on a documented service plan according to place of

service. (7-1-25)T

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. (7-1-25)T

b. CFH/RALF service plans must meet applicable licensing requirements for each residence type. (7-1-25)T

02. Supervision. An RN or QIDP provides oversight of PCS as required by the Department. Activities include: (7-1-25)T

a. Service plan development assistance, including in-home active treatment plans. (7-1-25)T

b. Review of treatment provided and verified by service delivery records and through on-site participant interviews. (7-1-25)T

c. Service plan re-evaluations, including on-site visits to evaluate change in a participant's condition as needed. (7-1-25)T

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. (7-1-25)T

03. PA. Authorizations are based on the participant's assessment, individual service plan, and any other medical information supporting medical needs. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

b. Participants or legal guardians must verify service delivery by signing the record. (7-1-25)T

c. Providers must sign the service plan indicating they will deliver services according to the authorization and consistent with HCBS requirements. (7-1-25)T

d. EVV systems described do not replace documentation requirements but may be used to generate documentation. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. No other qualified providers are available; (7-1-25)T

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 (7-1-25)T

c. A supervising QIDP provides monthly oversight visits until the direct care worker graduates from the training program. (7-1-25)T

03. Children's PCS Delivered in a Provider's Home. Providers must be licensed or certified as a child foster care or PCS FACH. (7-1-25)T

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. (7-1-25)T

05. Personal Assistance Agency (PAA) and Fiscal Intermediaries. (7-1-25)T

a. Recruit, hire, fire, train, supervise, schedule, process payroll, and ensure all direct care staff are qualified to provide quality services; (7-1-25)T

b. Maintain liability insurance coverage; (7-1-25)T

c. Ensure staffing of an RN or, when applicable, a QIDP supervisor to develop and complete service plans and provide supervision of service delivery; (7-1-25)T

d. Assign qualified staff to participants honoring their choices; and (7-1-25)T

e. Conduct annual participant satisfaction or quality control reviews available to the Department and the public. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

04. CFH and RALF Rates. PCS rates for residents are paid based on their assessed care level as follows: (7-1-25)T

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. (7-1-25)T

b. Level II, any diagnosis EXCEPT SPMI, DD, ADRD = one and five tenths (1.5) hrs/day. (7-1-25)T

c. Level III, any diagnosis = two and twenty-five hundredths (2.25) hrs/day. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Right Care. Standard of care for the diagnosis, functional needs, and abilities to achieve the desired outcome. (7-1-25)T

02. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (7-1-25)T

03. Right Price. The most integrated and least expensive services that are sufficient to address the participant's needs as identified in the assessment. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

01. Impairment. Impairment is attributed to one (1) of the following: (7-1-25)T

a. Intellectual Disability. (7-1-25)T

i. IQ test score of seventy (70) or below with a five (5) point standard error of measurement; or (7-1-25)T

ii. A delay of thirty percent (30%) overall on a functional assessment when under the age of five (5). (7-1-25)T

b. Cerebral Palsy. (7-1-25)T

c. Epilepsy, except when seizure-free and not on medication for three (3) years. (7-1-25)T

d. Autism with pervasive developmental disorder. (7-1-25)T

e. Other conditions closely related or similar to a-d. requiring similar treatment or services: (7-1-25)T

i. IQ test score above seventy-five (75) when functional limitations create a condition like intellectual disability. (7-1-25)T

ii. Disruption in motor function like cerebral palsy. (7-1-25)T

iii. Disorder causing interruption of consciousness like epilepsy. (7-1-25)T

iv. Not a mental illness. (7-1-25)T

f. Dyslexia resulting from a-e. (7-1-25)T

02. Substantial Functional Limitations. The impairment requires a combination and sequence of services that need to be individually planned and coordinated for substantial functional limitations within three (3) major life activities in b-h. (7-1-25)T

a. Substantial functional limitations are demonstrated by having a score of two (2) standard deviations below the mean. Participants under three (3) years of age can alternatively by: (7-1-25)T

i. Scoring thirty percent (30%) below age norm; or (7-1-25)T

ii. Exhibiting a six (6) month delay. (7-1-25)T

b. Self-care. (7-1-25)T

i. Under Age twenty-one (21): Manifested when age-appropriate skills are limited, and substantial assistance is required. (7-1-25)T

ii. Age twenty-one (21) and Over: Manifested when the person requires assistance in performing eating, hygiene, grooming, or health care skills, or the time to complete these tasks causes substantial impairment of conducting other ADL or retaining employment. (7-1-25)T

c. Receptive and expressive language. (7-1-25)T

i. Under Age three (3): Manifested when they have been diagnosed with performance thirty percent (30%) below age norm (adjusted for prematurity up to two (2) years) or demonstrated at least two (2) standard deviations below the mean in either area or one-and-one half (1 1/2) below in both areas of language development. (7-1-25)T

ii. Age three (3) and Above: Manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). (7-1-25)T

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. (7-1-25)T

e. Mobility. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

f. Self-direction. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

g. Capacity for independent living. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

h. Economic self-sufficiency. (7-1-25)T

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). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Abuse, Fraud, or Substandard Care. Suspected abuse, fraud, or substandard care is referred to the Department and other applicable agencies. (7-1-25)T

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. (7-1-25)T

567. (RESERVED)

568. ADULT DD SERVICES: DEFINITIONS.

01. Clinical Review. Process of professional review to validate the need for continued services. (7-1-25)T

02. Exception Review. Clinical review of a plan falling outside established standards due to a health or safety risk. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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 (7-1-25)T

b. The specific supports or services being requested, including type and frequency if applicable, that will address the identified need. (7-1-25)T

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. (7-1-25)T

05. Safety. Prevention of criminal activity, destruction of property, or injury or harm to self or others. (7-1-25)T

06. Safety Risks. Must be documented by the following: (7-1-25)T

a. Current incident reports; (7-1-25)T

b. Police reports; (7-1-25)T

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 (7-1-25)T

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). (7-1-25)T

e. Such documentation must establish: (7-1-25)T

i. An imminent or likely safety risk; and (7-1-25)T

ii. The specific supports or services that are being requested, including the type and frequency if applicable, that are likely to prevent that risk. (7-1-25)T

569. ADULT DD SERVICES: ELIGIBILITY DETERMINATION.
Participants aged eighteen (18) or older are eligible for adult DD services when they meet DD determination standards. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Assessment. The assessment with a Department-approved tool for DD service eligibility is required for all participants prior to plan development and includes: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

c. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (7-1-25)T

d. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

04. No Duplication of Services. The plan developer ensures that there is no duplication of services. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Exceptions. A PIP is not required for providers of: (7-1-25)T

i. Specialized medical equipment; (7-1-25)T

ii. Home-delivered meals; (7-1-25)T

iii. Environmental accessibility adaptations; (7-1-25)T

iv. Non-Medical Transportation; (7-1-25)T

v. Personal Emergency Response System; (7-1-25)T

vi. Respite care; (7-1-25)T

vii. Chore services; (7-1-25)T

viii. Community crisis support services; (7-1-25)T

ix. Adult DD service coordination; and (7-1-25)T

x. Adult Day Health. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

09. Addendum to the Service Plan. (7-1-25)T

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. (7-1-25)T

b. The Department distributes a copy of the authorized addendum to providers responsible for the implementation of the plan. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

11. Notifications. The Department notifies participants of its decision on their service plan. Notification includes an individualized explanation and how to appeal. (7-1-25)T

574. ADULT DD SERVICES: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee-for-service basis based on a participant budget. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

b. Supported employment is needed for the participant to obtain or maintain employment. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. (7-1-25)T

ii. History of predatory sexual offenses and at high risk to re-offend. (7-1-25)T

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. (7-1-25)T

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring, without which would require placement in a NF, hospital, or ICF/IID with twenty-four- (24) hour on-site nursing. (7-1-25)T

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: (7-1-25)T

i. A participant is eligible for high support; (7-1-25)T

ii. Supported employment is included in the service plan, causing the combination to exceed the daily limit; (7-1-25)T

iii. Documentation confirming the Person-Centered Planning team explored other options including lower-cost services and supports; and (7-1-25)T

iv. A participant's health and safety needs can be met using hourly services. (7-1-25)T

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). (7-1-25)T

01. Community. Natural, integrated environments outside of the participant's home, outside of DDA center-based settings, or at school outside of school hours. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

581. CHILDREN'S DD HCBS STATE PLAN OPTION: ELIGIBILITY DETERMINATION.
Eligibility also applies to Family-Directed Community Supports (FDCS). (7-1-25)T

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. (7-1-25)T

02. Individualized Budget Methodology. The following categories are used to determine individualized budgets for children with DD. (7-1-25)T

a. Level I. Children meeting DD criteria. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Not be provided to enable an unpaid caregiver to work. (7-1-25)T

b. Only participants living with an unpaid caregiver are eligible. (7-1-25)T

c. Cannot exceed fourteen (14) consecutive days. (7-1-25)T

d. Must not be provided at the same time as other Medicaid services except family education for an unpaid caregiver. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Not supplant services provided in school or therapy, or the role of a primary caregiver; (7-1-25)T

b. Ensure involvement in age-appropriate activities in integrated settings; and (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

05. Limitations for State Plan and Family-Directed Community Supports (FDCS). (7-1-25)T

a. Services are limited by the participant's individualized budget amount. (7-1-25)T

b. Services offered under the Medicaid Basic Plan cannot be authorized. (7-1-25)T

c. Duplication of services cannot be provided: (7-1-25)T

i. Goals are not separate and unique to each item or service provided; or (7-1-25)T

ii. When more than one (1) service is provided at the same time, unless otherwise authorized. (7-1-25)T

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. (7-1-25)T

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). (7-1-25)T

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). (7-1-25)T

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). (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

IAC ARCHIVE 2025

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. (7-1-25)T

07. Annual Reauthorization for State Plan and Family-Directed Community Supports (FDCS). (7-1-25)T

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. (7-1-25)T

02. Quality Assurance. Providers must demonstrate high quality of services through internal quality assurance reviews. (7-1-25)T

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: (7-1-25)T

a. Visit date and time in and out; (7-1-25)T

b. Services provided; (7-1-25)T

c. Session summary; (7-1-25)T

d. Service location; and (7-1-25)T

e. Signature of the provider and date signed. (7-1-25)T

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: (7-1-25)T

a. Be at least sixteen (16) years old when employed by a DDA or eighteen (18) years old when an independent provider; (7-1-25)T

b. Receive instructions in the participant’s needs; (7-1-25)T

c. Demonstrate ability to provide services according to a service plan; and (7-1-25)T

d. Obtain and maintain CPR and first aid certification prior to delivering services. (7-1-25)T

02. Community-Based Support. Provided by a DDA or an independent provider meeting these minimum qualifications: (7-1-25)T

a. Be at least eighteen (18) years old; (7-1-25)T

b. Receive instructions in the participant’s needs; (7-1-25)T

c. Demonstrate ability to provide services according to a service plan; (7-1-25)T

d. Be supervised or have six (6) months supervised experience working with children with DD. (7-1-25)T

e. Complete coursework approved by the Department demonstrating competencies related to providing community-based supports; and (7-1-25)T

f. Obtain and maintain CPR and first aid certification prior to delivering services alone. (7-1-25)T

03. Family Education. Provided by a DDA or an independent intervention specialist or professional. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

IAC ARCHIVE 2025

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. (7-1-25)T

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. (7-1-25)T

c. Not include tutorial activities or assistance with educational tasks associated with educational needs resulting from a disability. (7-1-25)T

d. Both individual and group therapy must be available based on participant needs, interests, or choices. (7-1-25)T

e. Include a minimum of one (1) qualified staff member providing direct services for every twelve (12) participants when center based. (7-1-25)T

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. (7-1-25)T

02. Limitations. Developmental therapy may not exceed these limitations: (7-1-25)T

a. No more than twenty-two (22) hours per week. (7-1-25)T

b. No more than forty (40) hours per week in combination with ADH and supported employment. (7-1-25)T

c. Only one (1) type of Medicaid-reimbursable therapy during a single period. (7-1-25)T

d. Cannot be reimbursed when providing transportation to and from the agency. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. IPP Development. IPPs must: (7-1-25)T

a. Be developed after completion of all required assessments; (7-1-25)T

b. Be signed prior to delivery of services by a medical provider, the participant, and their legal guardian if applicable; (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Reason for a change; (7-1-25)T

b. Coordination with other service providers, when applicable; (7-1-25)T

c. Date of change; and (7-1-25)T

d. Signature, date, credentials, and title of the professional making the change. (7-1-25)T

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: (7-1-25)T

01. Comprehensive Developmental Assessment. Assessments must: (7-1-25)T

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. (7-1-25)T

b. Be signed and dated by the professional completing the assessment, including their appropriate professional credentials or qualifications. (7-1-25)T

c. Reflect the current status of the participant with assessments completed or updated at least every two (2) years. (7-1-25)T

d. Reflect a person's developmental status in the following areas: (7-1-25)T

i. Self-care; (7-1-25)T

ii. Receptive and expressive language; (7-1-25)T

iii. Learning; (7-1-25)T

iv. Gross and fine motor development; (7-1-25)T

v. Self-direction; (7-1-25)T

vi. Capacity for independent living; and (7-1-25)T

vii Economic self-sufficiency. (7-1-25)T

02. Specific Skill Assessments. These assessments must: (7-1-25)T

a. Further assess an area of limitation or deficit identified on a comprehensive developmental assessment. (7-1-25)T

b. Relate to a goal on an IPP or ISP. (7-1-25)T

c. Be conducted by qualified professionals to determine a participant's skill level within an area. (7-1-25)T

d. Be used to determine baselines and develop a PIP. (7-1-25)T

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: (7-1-25)T

a. Daily entry of all activities conducted toward meeting their objectives. (7-1-25)T

b. Sufficient progress data accurately assessing a participant's progress toward each objective; (7-1-25)T

c. Review of data, and, when applicable, changes in the daily activities or implementation procedures by the qualified professional, including their dated initials. (7-1-25)T

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. (7-1-25)T

e. Authorized service plan. (7-1-25)T

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: (7-1-25)T

a. Participant's name. (7-1-25)T

b. A baseline statement addressing the participant's skill level and abilities related to specific skills to be learned. (7-1-25)T

c. Measurable, behaviorally stated objectives corresponding to the goals or objectives authorized in the service plan. (7-1-25)T

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. (7-1-25)T

e. Identification of the environments where services are provided. (7-1-25)T

f. Target date for completion. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-25)T

b. Possess a bachelor's or master's degree in any area and have: (7-1-25)T

i. Completed a competency course approved by the Department relating to Developmental Specialist job requirements; and (7-1-25)T

ii. Passed a Department-approved competency examination. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. DDAs must ensure paraprofessionals do not conduct assessments, establish service plan, or develop a PIP. These activities are conducted by a Developmental Specialist. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

611. ADULT DD WAIVER SERVICES: PARTICIPANT ELIGIBILITY.
The Department determines waiver eligibility. The participant must meet the following: (7-1-25)T

01. Age. Be eighteen (18) years or older. (7-1-25)T

02. Eligibility. The Department must determine whether: (7-1-25)T

a. The participant would qualify for ICF/IID level of care if the DD waiver services were not available; (7-1-25)T

b. The participant can reside safely and effectively in a non-institutional setting; and (7-1-25)T

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. (7-1-25)T

03. DD Waiver Eligibility. Participants eligible for DD waiver services may instead choose admission to an ICF/IID. (7-1-25)T

04. Redetermination. (7-1-25)T

a. Financial and medical redetermination are conducted annually or sooner at the request of the participant, self-reliance, a provider agency, or medical provider. (7-1-25)T

b. The redetermination process will assess the participant's continued need and eligibility for waiver services and discharge from the waiver services program. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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: (7-1-25)T

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life

activities; (7-1-25)T

ii. Money management; (7-1-25)T

iii. Daily living skills; (7-1-25)T

iv. Socialization not including participation in non-therapeutic activities that are diversional or recreational in nature; (7-1-25)T

v. Mobility; and (7-1-25)T

vi. Behavior shaping and management. (7-1-25)T

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. (7-1-25)T

c. Skills training to teach participants and supports to perform activities with greater independence and to reinforce habilitation training. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

07. Specialized Medical Equipment and Supplies. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

c. Items reimbursed under this waiver exclude items that are not of direct medical or remedial benefit to the participant. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

13. Self-Directed Community Supports. DD waiver participants may choose to self-direct an individualized budget rather than receive traditional waiver services. (7-1-25)T

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. (7-1-25)T

a. Services may include: (7-1-25)T

i. Security deposits required to obtain a lease on an apartment or home; (7-1-25)T

ii. Cost of essential household furnishings; (7-1-25)T

iii. Set-up fees or deposits for utility or service access; (7-1-25)T

iv. Services necessary for health and safety prior to occupancy; (7-1-25)T

v. Moving expenses; and (7-1-25)T

vi. Activities to assess need, arrange for, and procure transition services. (7-1-25)T

b. Exclusions. Ongoing expenses (including utilities), real property, décor, or entertainment and recreational items. (7-1-25)T

IAC ARCHIVE 2025

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. (7-1-25)T

15. Limitations. Participants cannot receive DD waiver services in non-HCBS settings or RALFs. (7-1-25)T

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. (7-1-25)T

02. Documentation Required. (7-1-25)T

a. Written documentation of each visit made or service provided to a participant including: (7-1-25)T

i. Service date; (7-1-25)T

ii. Service(s) provided; (7-1-25)T

iii. Statement of the participant's response to services, including any changes in the participant's condition; (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

c. PIP and provider status reviews, if required. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Be at least eighteen (18) years old; (7-1-25)T

b. Be free from communicable disease; (7-1-25)T

c. Demonstrate the ability to administer the plan of service; (7-1-25)T

d. Have a valid driver's license and vehicle insurance, if transporting participants; (7-1-25)T

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. (7-1-25)T

02. Residential Habilitation – CFH. Individuals providing direct services in their own home must be a CFH, receive program coordination provided through the Department, and: (7-1-25)T

a. Be free from communicable disease; (7-1-25)T

b. Have a valid driver's license and vehicle insurance, if transporting participants; and (7-1-25)T

c. Have certification or licensure to perform tasks requiring certification or licensure. (7-1-25)T

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. (7-1-25)T

03. Chore Services. Be skilled in the service to be provided and demonstrate the ability to follow a service plan. (7-1-25)T

04. Respite Care. Receive instructions in the participant's needs, demonstrate the ability to follow a service plan, and be free of communicable disease. (7-1-25)T

05. Supported Employment. Provided by an agency accredited by CARF or meet State requirements to be an agency. (7-1-25)T

06. Non-Medical Transportation. Possess a valid driver's license and vehicle insurance. (7-1-25)T

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. (7-1-25)T

08. PERS. Demonstration that the devices installed in a participant's home meet FCC standards. (7-1-25)T

09. Home-Delivered Meals. Provided by a public agency or business ensuring: (7-1-25)T

a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the USDA; (7-1-25)T

b. Meals are delivered in a sanitary manner, and at the correct temperature for the specific type of food; and (7-1-25)T

c. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions. (7-1-25)T

10. Behavior Consultation or Crisis Management. (7-1-25)T

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 (7-1-25)T

i. Have a Master's degree in a behavioral science or a closely related field; (7-1-25)T

ii. Be a licensed pharmacist; or (7-1-25)T

iii. Be a QIDP. (7-1-25)T

b. Emergency back-up providers must meet the qualifications of a residential habilitation agency. (7-1-25)T

11. Adult Day Health. (7-1-25)T

a. Services provided in a facility must meet the building and health standards under IDAPA 16.03.21; (7-1-25)T

b. Provide care and supervision appropriate to the participant's needs as identified on the plan. (7-1-25)T

c. Free from communicable disease. (7-1-25)T

12. Transition Services. Transition managers. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

625. HEALTH HOME: PROVIDER REIMBURSEMENT.
Reimbursement for Health Home services will be paid per the fee schedule. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Age of thirty-seven (37) months through the month of their 21st birthday. (7-1-25)T

b. A diagnosis with special health care needs requiring medical and multidisciplinary rehabilitation services identified by a medical provider to prevent or minimize disability. (7-1-25)T

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: (7-1-25)T

i. A condition resulting in functioning below normal age level in one (1) or more life areas; (7-1-25)T

ii. At risk of placement in a more restrictive environment or returning a child from an out of home placement due to their condition; (7-1-25)T

iii. Danger to the health or safety of the child exists or a parent is unable to meet the child's needs; (7-1-25)T

iv. Further complications may occur due to the condition without service coordination; or (7-1-25)T

v. Requires multiple service providers and treatments. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Services are provided according to the plan; (7-1-25)T

b. Services in the plan are adequate; and (7-1-25)T

c. Whether there are changes in the needs or status of a participant, requiring adjustments to the plan

or service arrangements with providers. (7-1-25)T

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. (7-1-25)T

a. Crisis Assistance hours are unavailable until all available hours of service coordination have already been provided in the month. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

07. Limitations. (7-1-25)T

a. Providers may only deliver service coordination and direct services to the same Medicaid participant when they receive children's services coordination. (7-1-25)T

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. (7-1-25)T

c. Reimbursement for annual assessment and plan development cannot exceed twelve (12) hours per year. (7-1-25)T

d. Participants receiving hospice services or who live in hospitals, NFs, or ICF/IIDs are not eligible for service coordination. (7-1-25)T

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. (7-1-25)T

f. Group services are not reimbursable. (7-1-25)T

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. (7-1-25)T

633. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization. (7-1-25)T

02. Plan Development. A plan must be developed and implemented within sixty (60) days after a participant chooses a service coordinator. (7-1-25)T

03. Documentation. Agencies must maintain documentation describing services provided, reviewing the continued need for service coordination, and progression towards each service coordination goal. (7-1-25)T

04. Freedom of Choice. A participant must have freedom of choice when selecting providers. (7-1-25)T

IAC ARCHIVE 2025

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

a. Providers developing a participant's plan cannot: (7-1-25)T

i. Be related by blood or marriage to the participant or to any paid caregiver of the participant; (7-1-25)T

ii. Be financially responsible for the participant; (7-1-25)T

iii. Make financial or health-related decisions on behalf of the participant; (7-1-25)T

iv. Hold financial interests in any entity paid to provide care for the participant; or (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

634. SERVICE COORDINATION: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Agreement. Providers must be employees or contractors of an agency. (7-1-25)T

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. (7-1-25)T

03. Supervisor Requirements. (7-1-25)T

a. Master's Degree in a human services field, and twelve (12) months supervised work experience with the population served; or (7-1-25)T

b. Bachelor's degree in a human services field or RN, and twenty-four (24) months supervised work experience with the population served. (7-1-25)T

04. Service Coordinator Requirements. (7-1-25)T

a. Bachelor's degree in a human services field or RN and twelve (12) months supervised work experience with the population served. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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 (7-1-25)T

b. Be able to read and write at a level necessary to process all paperwork and forms required for service delivery. (7-1-25)T

06. Health, Safety, and Fraud Reporting. Providers must report any concerns about fraud, health, and safety to the appropriate governing agency and the Department. (7-1-25)T

07. Case Loads. The total caseload of a provider must assure quality service delivery and participant satisfaction. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

637. SERVICE COORDINATION: REIMBURSEMENT.

01. Duplication. Payments must not duplicate payment made under similar programs. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

b. Services must not duplicate activities provided during a facility's admission or discharge process. (7-1-25)T

04. Delivered Prior to Assessment. On-going service coordination is not allowable prior to completion of a plan. (7-1-25)T

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: (7-1-25)T

01. Evaluation. The child's current behavioral health, living situation, relationships, and family functioning; (7-1-25)T

02. Contact. Necessary contacts with significant individuals; and (7-1-25)T

03. History. Review of a child's clinical, educational, social, and behavioral health, and juvenile justice history. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Person-Centered Planning. A person-centered planning team directs the development of the service plan. (7-1-25)T

643. – 649. (RESERVED)

**SUB AREA: HOSPICE
(Sections 650-659)**

650. HOSPICE.
Medicaid pays for hospice services based on Medicare program coverage. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

03. Hospice Agency. Public agency or private organization that primarily provides care to terminally ill participants and meets the Medicare conditions for certification. (7-1-25)T

652. HOSPICE: ELIGIBILITY.
Hospice eligibility requires: (7-1-25)T

01. Certification of Participant Terminal Illness. (7-1-25)T

02. Medically Necessary. For the palliation and management of a terminal illness and related conditions. (7-1-25)T

03. Participant Election of Services. (7-1-25)T

04. Informed Consent. Participants must receive education on the reason for and nature of hospice care prior to service delivery. (7-1-25)T

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. (7-1-25)T

654. HOSPICE: PROCEDURAL REQUIREMENTS.

01. Physician Certification. The hospice must obtain certification of a participant's terminal illness as follows: (7-1-25)T

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. (7-1-25)T

b. Maintain monthly certification statements for review. (7-1-25)T

c. Notify Medicaid when a participant's designated attending physician is not a hospice employee. (7-1-25)T

02. Election Procedures. A participant or their representative must request hospice care by submitting an election statement to a hospice of their choice. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

i. Available hospice days did not exceed two hundred ten (210) days in a benefit period due to loss of financial eligibility; (7-1-25)T

ii. Hospices were not changed excessively; and (7-1-25)T

iii. More than eight (8) election periods were not revoked. (7-1-25)T

c. A participant cannot request an effective date earlier than the date of their election. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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: (7-1-25)T

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. (7-1-25)T

b. Multiplying excess inpatient care days by the routine home care rate. (7-1-25)T

c. Adding the two (2) calculated amounts and comparing the sum to interim inpatient hospice care payments made during the "cap period." (7-1-25)T

02. Limitation Cap. When any interim payments for inpatient care exceed the limitation, a provider must return the amount over the limitation. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. Overall Cap. The cap is compared to reimbursement after computing the inpatient limitation and subtracting from the total reimbursement amount. (7-1-25)T

02. Total Payment. All payments for services rendered during a cap year, regardless of when payment is made. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

05. Certified Mid-Month. A weighted average cap amount based on the number of days falling within each cap period is used. (7-1-25)T

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. (7-1-25)T

a. Each hospice's adjusted cap amount is computed as follows: (7-1-25)T

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." (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

661. – 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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Evidence of Coverage. Contract between an MCO and the participant detailing covered services. (7-1-25)T

03. Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP). Health plan option that fully integrates Medicare and Medicaid benefits under a single MAO. (7-1-25)T

04. Idaho Medicaid Plus (IMPlus). MMCP health plan option where most Medicaid covered services are provided by one MCO. (7-1-25)T

05. Medicare Advantage Organizations (MAOs). MCO approved by CMS to offer Medicare Advantage Plans. (7-1-25)T

06. Medicare Advantage Plan. Private health plans contracted with CMS to provide Medicare Parts A, B, and D benefits. (7-1-25)T

07. Medicare/Medicaid Coordinated Plan (MMCP). MMCP health plan option integrating Medicare and Medicaid covered services under a FIDE-SNP provided by one MCO. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

01. IMPlus. CMS approval of MCO under 1915(b) authority. (7-1-25)T

02. MMCP. CMS approval of MAO to operate a Medicare Advantage Plan. (7-1-25)T

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. (7-1-25)T

01. Exclusions. Individuals receiving Adult DD 1915(c) waiver benefits are excluded from IMPlus enrollment. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Limitations. Services not included in the Evidence of Coverage are carved out and provided under fee-for-service Medicaid or other contracted entities. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

06. Lawfully Residing. Residing in a manner not contrary to or forbidden by law, and with the participant's knowledge and consent. (7-1-25)T

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. (7-1-25)T

08. Personal Property. Any property that is not real property, including cash, jewelry, household goods, tools, life insurance policies, boats, and wheeled vehicles. (7-1-25)T

09. Real Property. Any land, including buildings or immovable objects attached permanently to the land. (7-1-25)T

10. Residing in the Home on a Continuous Basis. Occupying and continuing to occupy the home as the primary residence. (7-1-25)T

11. Termination of a Lien. The release or dissolution of a lien from property. (7-1-25)T

12. Undue Hardship. Conditions that justify waiver or deferral of all or a part of the Department's claim against an estate. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. The participant must meet the criteria for NF or ICF/IID level of care and services; (7-1-25)T

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 (7-1-25)T

c. Where the prognosis indicated in the medical records is uncertain or inconclusive, the Department may request additional medical information or may delay the determination until the next utilization control review or annual Inspection of Care review, as appropriate. (7-1-25)T

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: (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. The name and last known address of the participant; and (7-1-25)T

b. The name and address of the official or agent of the Department filing the lien; and (7-1-25)T

c. A brief description of the medical assistance received by the participant; and (7-1-25)T

d. The amount paid by the Department, as of a given date, and, if applicable, a statement that the amount of the lien will increase as long as medical assistance benefits are paid on behalf of the participant. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Payments to the participant under an installment contract will be included among the assets of the deceased participant. This includes an installment contract on any real or personal property to which the deceased

participant had a property right. The value of a promissory note, loan or property agreement is its outstanding principal balance at the date of death of the participant. When a promissory note, loan, or property agreement is secured by a Deed of Trust, the Department may request evidence of a reasonable and just underlying debt.(7-1-25)T

b. The deceased participant's ownership interest in another person's estate, probated or not probated, is an asset of their estate when: (7-1-25)T

i. Documents show the deceased participant is an eligible devisee or donee of property of another deceased person; or (7-1-25)T

ii. The deceased participant received income from property of another person; or (7-1-25)T

iii. State intestacy laws award the deceased participant a share in the distribution of the property of another estate. (7-1-25)T

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. (7-1-25)T

d. Life insurance is considered an asset when it has reverted to the estate. (7-1-25)T

e. Burial insurance is considered an asset when a funeral home is the primary beneficiary or when there are unspent funds in the burial contract. Any funds remaining after payment to the funeral home will be considered assets of the estate. (7-1-25)T

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. (7-1-25)T

g. In a conservatorship situation, if a court order under state law specifically requires funds be made available for the care and maintenance of a participant prior to 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. (7-1-25)T

h. Shares of stocks, bonds, and mutual funds to the benefit of the deceased participant are assets of the estate. (7-1-25)T

05. Value of Estate Assets. The Department will use fair market value as the value of the estate assets. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Funeral expenses reasonably necessary for burial or cremation services approved on a case-by-case basis at the discretion of the Department. (7-1-25)T

b. Administrative expenses of the estate may be deducted in accordance with Section 56-218, Idaho Code. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

a. Neither the Medicaid participant or their spouse ever owned the remainder interest; or (7-1-25)T

b. The life estate was created prior to July 1, 1995. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

b. Undue hardship waivers will be considered in the following circumstances: (7-1-25)T

i. The estate subject to recovery is income-producing property that provides the sole source of support for heirs; or (7-1-25)T

ii. Payment of the Department's claim would cause heirs of the deceased participant to be eligible for public assistance; or (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

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; (7-1-25)T

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 (7-1-25)T

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. (7-1-25)T

02. Forms - Content. The notices must include the following information: (7-1-25)T

a. The name of the public assistance recipient and the spouse of such public assistance recipient, if any; (7-1-25)T

b. The Medicaid number for the public assistance recipient and spouse, if any; (7-1-25)T

c. The legal description of the real property affected or to be affected; (7-1-25)T

d. The mailing address at which the Department is to receive notice; (7-1-25)T

e. If the document is a Notice of Transfer or Encumbrance, the name and address of the transferee or lien holder; and (7-1-25)T

f. A fully executed acknowledgment as required for recording under Section 55-805, Idaho Code. (7-1-25)T

03. Webpages for Forms. These forms may be found at http://healthandwelfare.idaho.gov. (7-1-25)T

a. Notice of Transfer or Encumbrance. (7-1-25)T

b. Request for Notice. (7-1-25)T

c. Termination of Request for Notice. (7-1-25)T

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. (7-1-25)T

991. LOCK-IN DEFINED.
Lock-in is the process of restricting the access of a participant to a specific provider or providers. (7-1-25)T

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. (7-1-25)T

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: (7-1-25)T

01. Unnecessary Use of Providers or Services, Including Excessive Provider Visits. (7-1-25)T

02. Demonstrated Abusive Patterns. Recommendation from a provider that the participant has demonstrated abusive patterns and would benefit from the lock-in program. (7-1-25)T

03. Use of Emergency Room. Frequent use of emergency room for non-emergent conditions. (7-1-25)T

04. Multiple Providers. (7-1-25)T

05. Controlled Substances. (7-1-25)T

06. Use of Multiple Prescribing Providers or Pharmacies. (7-1-25)T

07. Overlapping Prescription Drugs With the Same Therapeutic Classes. (7-1-25)T

08. Drug Abuse. (7-1-25)T

09. Drug-Seeking Behavior. As identified by a provider. (7-1-25)T

10. Other Abusive Utilization. As determined by the Department's medical or pharmacy consultant. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

02. Appeal Stays Restriction. The Department will not implement the participant restriction if a valid appeal is noted. (7-1-25)T

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. (7-1-25)T

04. Payment to Providers. Payment to providers other than the designated lock-in provider or pharmacy is limited to documented emergencies or referrals. (7-1-25)T

05. Regional Programs Manager. The Regional Programs Manager will: (7-1-25)T

a. Clearly describe the participant's appeal rights; (7-1-25)T

b. Specify the effective date and length of the restriction; (7-1-25)T

c. Have the participant choose a designated provider or providers; and (7-1-25)T

d. Mail the completed lock-in agreement to the Surveillance and Utilization Unit. Upon receipt of the lock-in agreement, the participant's Medicaid services will be immediately restricted to the designated providers. (7-1-25)T

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. (7-1-25)T

997. APPEAL OF LOCK-IN.
Department determinations to lock-in a participant may be appealed. (7-1-25)T

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. (7-1-25)T

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. (7-1-25)T

999. (RESERVED)

ARCHIVE