

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0905

### NOTICE OF RULEMAKING - PROPOSED RULE

**AUTHORITY:** In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56- 202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, October 21, 2009.

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

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

These rules are being amended in response to the federal audit conducted by Centers for Medicare and Medicaid Services (CMS) for the period of July 1, 2006, through June 30, 2007, on the Personal Care Services (PCS) program. In order to comply with the recommendations from CMS, the Department is changing the payment methodology for children receiving PCS in a PCS home and establishing rules specific to PCS for children.

The following is the summary of the proposed changes:

1. Update the current rules for Personal Care Services (PCS) to reflect changes in the payment methodology for PCS homes;
2. Separate, align, clarify, and augment the rules that govern adult PCS and children's PCS; and
3. Clarify PCS medication rules.

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

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

The projected fiscal impact is a total savings of \$445,700; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately \$84,922.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted. Negotiated rulemaking was not conducted because these rule changes are being made in response to a federal audit.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Susan Choules at (208) 364-1891.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, October 28, 2009.

DATED this 2nd day of September, 2009.

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**THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-0905**

**301. ~~(RESERVED)~~ PERSONAL CARE SERVICES - DEFINITIONS.**

**01. Children's PCS Assessment.** A set of standardized criteria adopted by the Department to assess functional and cognitive abilities of children to determine eligibility for children's personal care services. ( )

**02. Natural Supports.** Personal associations and relationships that enhance the quality and security of life for people, such as family, friends, neighbors, volunteers, church, or others. ( )

**03. Personal Care Services (PCS).** A range of medically-oriented care services related to a participant's physical or functional requirements. These services are provided in the participant's home or personal residence, but do not include housekeeping or skilled nursing care. ( )

**04. PCS Family Alternate Care Home.** The private home of an individual licensed by the Department to provide personal care services to one (1) or two (2) children, who are unable to reside in their own home and require assistance with medically-oriented tasks related to the child's physical or functional needs. ( )

**302. PERSONAL CARE SERVICES - ELIGIBILITY.**

**01. Financial Eligibility.** The participant must be financially eligible for medical assistance under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

**02. Other Eligibility Requirements.** Regional Medicaid Services (RMS) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (3-19-07)

**a.** The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS. (3-19-07)

**b.** The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed; ~~A UAI is not to be completed for a child participant~~ or a child for whom a children's PCS assessment has been completed; (3-19-07)( )

**c.** The RMS reviews the documentation for medical necessity; and (4-2-08)

**d.** The participant has a plan of care. (4-2-08)

**03. State Plan Option.** A participant who receives medical assistance is eligible for PCS under the State Medicaid Plan option if the Department finds he requires PCS due to a medical condition that impairs his physical or mental function or independence. (3-19-07)

**04. Annual Eligibility Redetermination.** The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. (3-19-07)

**a.** The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." RMS must make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QMRP, or the physician. (4-2-08)

**b.** The medical redetermination must assess the following factors: (3-19-07)

**i.** The participant's continued need for PCS; (3-19-07)

**ii.** Discharge from PCS; and (3-19-07)

**iii.** Referral of the participant from PCS to a nursing facility. (3-19-07)

**303. PERSONAL CARE SERVICES (~~PCS~~) - COVERAGE AND LIMITATIONS.**

**01. Medical Care and Services.** PCS services include medically-oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence. The provider must deliver at least one (1) of the following services: (3-19-07)

**a.** Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; (3-19-07)

**b.** Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines; (3-19-07)

**c.** ~~Assisting the participant with physician ordered medications that are ordinarily self administered, such as opening the packaging or reminding the participant to take medications~~ Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (~~3-19-07~~)( )

**d.** ~~Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need~~ The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the participant with developmental disabilities; (~~3-19-07~~)( )

**e.** ~~The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the developmentally disabled participant~~ Assisting the participant with physician-ordered medications that are ordinarily self-administered, in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," Subsection 490.05; (~~3-19-07~~)( )

**f.** Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met: (3-19-07)

**i.** The task is not complex and can be safely performed in the given participant care situation; (3-19-07)

**ii.** A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs; (3-19-07)

**iii.** Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the

performance of the procedure at least monthly; (3-19-07)

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN; (3-19-07)

v. The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN and must be readily available for review, preferably with the participant's record; and (3-19-07)

vi. Routine medication may be given by the personal assistant through the non-nasogastric tube if authorized by the supervising RN. (3-19-07)

**02. Non-Medical Care and Services.** PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed in Subsections 303.01.a. through 303.01.f. of this rule, the provider may also perform the following services, if no natural supports are available: ~~(3-19-07)~~( )

a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded. (3-19-07)

b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment. (3-19-07)

c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant. (3-19-07)

**03. Place of Service Delivery.** PCS may be provided only in the participant's own home or personal residence. The participant's personal residence may be a Certified Family Home or a Residential Care or Assisted Living Facility, or a PCS Family Alternate Care Home. The following living situations are specifically excluded as a personal residence: ~~(3-19-07)~~( )

a. Certified nursing facilities or hospitals. (3-19-07)

b. Licensed Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). (3-19-07)

c. A home that receives payment for specialized foster care, professional foster care or group foster care, as described in IDAPA 16.06.01, "Child and Family Services." (3-19-07)

**04. Type of Service Limitations.** The provider is excluded from delivering the following services: (3-19-07)

a. Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; (3-19-07)

b. Insertion or sterile irrigation of catheters; (3-19-07)

c. Injecting fluids into the veins, muscles or skin; and (3-19-07)

d. Administering medication. (3-19-07)

**05. Participant Service Limitations.** (3-19-07)

a. Adults who receive PCS under the State Medicaid Plan option are limited to a maximum of sixteen (16) hours per week per participant. (3-19-07)

b. Children who meet the necessity criteria for EPSDT services under IDAPA 16.03.09 "Medicaid

Basic Plan Benefits,” Section 882, may receive up to twenty-four (24) hours per day of PCS per child through the month of their twenty-first birthday. (3-19-07)

**06. Provider Coverage Limitations.** (3-19-07)

**a.** The provider must not bill for more time than was actually spent in service delivery. (3-19-07)

**b.** No provider home, regardless of the number of providers in the home, may serve more than two (2) children who are authorized for eight (8) or more hours of PCS per day. (3-19-07)

**304. PERSONAL CARE SERVICES - PROCEDURAL REQUIREMENTS.**

**01. Service Delivery Based on Plan of Care or NSA.** All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, “Residential Care or Assisted Living Facilities in Idaho.” The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, “Rules Governing Certified Family Homes.” The Personal Assistance Agency and the participant who lives in his own home are responsible to prepare the plan of care. (3-19-07)

**a.** The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: ~~(3-19-07)~~( )

**i.** The physician's or authorized provider's information if applicable; (4-2-08)

**ii.** The results of the UAI for adults, the ~~Personal Assistance Agency's assessment for~~ children's PCS assessment and, if applicable, the QMRP's assessment and observations of the participant; and ~~(3-19-07)~~( )

**iii.** Information obtained from the participant. (3-19-07)

**b.** The plan of care must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type and frequency of necessary services. (3-19-07)

**c.** The plan of care must be revised and updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. (3-19-07)

**02. Service Supervision.** The delivery of PCS may be overseen by a licensed professional nurse (RN) or Qualified Mental Retardation Provider (QMRP). The RMS must identify the need for supervision. (3-19-07)

**a.** Oversight must include all of the following: (3-19-07)

**i.** Assistance in the development of the written plan of care; (3-19-07)

**ii.** Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-19-07)

**iii.** Reevaluation of the plan of care as necessary; and (3-19-07)

**iv.** Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. (3-19-07)

**b.** All participants who are developmentally disabled, other than those with only a physical disability as determined by the RMS, may receive oversight by a QMRP as defined in 42 CFR 483.430. Oversight must include: (3-19-07)

**i.** Assistance in the development of the plan of care for those aspects of active treatment which are provided in the participant's personal residence by the personal assistant; (3-19-07)

- ii. Review of the care or training programs given by the personal assistant through a review of the participant's PCS record as maintained by the provider and through on-site interviews with the participant; (3-19-07)
- iii. Reevaluation of the plan of care as necessary, but at least annually; and (3-19-07)
- iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the service coordinator or the participant. (3-19-07)

**03. Prior Authorization Requirements.** All PCS services must be prior authorized by the Department. Authorizations will be based on the information from: ( )

- a.** The children's PCS assessment or Uniform Assessment Instrument (UAI) for adults; ( )
- b.** The individual service plan developed by the Personal Assistance Agency; and ( )
- c.** Any other medical information that supports the medical need. ( )

**034. PCS Record Requirements for a Participant in His Own Home.** The PCS records must be maintained on all participants who receive PCS in their own homes or in a PCS Family Alternate Care Home. (3-19-07)( )

**a.** Written Requirements. The PCS provider must maintain written documentation of every visit made to the participant's home and must record the following minimum information: (3-19-07)

- i. Date and time of visit; (3-19-07)
- ii. Length of visit; (3-19-07)
- iii. Services provided during the visit; and (3-19-07)
- iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-19-07)

**b.** Participant's Signature. The participant must sign the record of service delivery verifying that the services were delivered. The RMS may waive this requirement if it determines the participant is not able to verify the service delivery. (3-19-07)

**c.** A copy of the information required in Subsection 304.03 of these rules must be maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. (3-19-07)

**d.** Telephone Tracking System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsection 304.03 of these rules. (3-19-07)

**e.** Participant in a Residential or Assisted Living Facility. The PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (3-19-07)

**f.** Participant in a Certified Family Home. The PCs record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (3-19-07)

**045. Provider Responsibility for Notification.** The Personal Assistance Agency is responsible to notify the RMS and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record.

(3-19-07)

**(BREAK IN CONTINUITY OF SECTIONS)**

**307. PERSONAL CARE SERVICES - PROVIDER REIMBURSEMENT.**

**01. Reimbursement Rate.** Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department on an annual basis according to Section 39-5606, Idaho Code. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

**02. Calculated Fee.** The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMS under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.07 of these rules. (3-19-07)

**03. Weighted Average Hourly Rates.** Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/MR, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used ~~for~~ in calculating the reimbursement rate to be effective on July 1st of that year. (3-19-07)( )

**04. Payment Levels for ~~PAA~~ Personal Assistance Agency.** ~~Medicaid~~ The Department will then establish ~~payment levels for~~ Personal Assistance ~~Agencies~~ Agency rates for personal assistance services ~~as follows:~~ (3-19-07)

~~a. Weekly service needs of zero to sixteen (0-16) hours under the State Medicaid Plan, or a HCBS waiver based on the WAHR, plus the WAHR times a fifty-five percent (55%) supplemental component to cover travel, administration, training, and all payroll taxes and fringe benefits, as follows:~~

Personal Assistance Agencies	WAHR x 1.55	=	\$ amount/hour
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(3-19-07)( )

~~b. Extended visit, one (1) child (eight and one quarter (8.25) hours up to twenty four (24) hours):~~

<del>Personal Assistance Agencies</del>	<del>(WAHR x actual hours of care up to 5 hours x 1.55) plus (\$.65 x 1.55 hours on site on call)</del>	=	<del>\$ amount/hour</del>
<del>Licensed Child Foster Homes</del>	<del>(WAHR x actual hours of care up to 5 hours x 1.22) plus (\$.65 x 1.22 x actual hours on site on call)</del>	=	<del>\$ amount/hour</del>

(3-19-07)

~~c. Extended visit, two (2) children (eight and one quarter (8.25) hours up to twenty four (24) hours):~~

<del>Personal Assistance Agencies</del>	<del>(WAHR x actual hours of care up to 4 hours) x (1.55 plus \$.65 x 1.55 x hours on site on call)</del>	=	<del>\$ amount/hour</del>
<del>Licensed Child Foster Homes</del>	<del>(WAHR x hours actual care up to 4 hours x 1.22) plus (\$.65 x 1.22 x hours on site on call)</del>	=	<del>\$ amount/hour</del>

(3-19-07)

**05. Payment Levels for Adults in Residential Care or Assisted Living Facilities or Certified Family Homes.** Adult participants living in Residential Care or Assisted Living Facilities (RCALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (3-19-07)

**a.** Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (3-19-07)

**b.** Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (3-19-07)

**c.** Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (3-19-07)

**d.** Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, mental retardation, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, mental retardation, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c of these rules. (3-19-07)

**06. Attending Physician Reimbursement Level.** The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-19-07)

**07. Supervisory RN and QMRP Reimbursement Level.** The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMS. (3-19-07)

**a.** The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMS. (3-19-07)

**b.** Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMS. (3-19-07)

**08. Payment for PCS Family Alternate Care Home.** The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR, plus the product of the WAHR times fifty-five percent (55%) less the current payroll tax and fringe benefit rate to cover travel, administration, and training, as follows:

<u>PCS Family Alternate Care Home</u>	<u>Children's PCS Assessment Weekly Hours x (WAHR x (1.55 minus payroll taxes and fringe benefits cost percentage)</u>	<u>=</u>	<u>\$ amount/week</u>
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