DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

JUN 0 6 2011

Richard Armstrong, Director
Department of Health and Welfare
Towers Building, Tenth Floor
Post Office Box 83720
Boise, Idaho 83720-0036

RE: Idaho State Plan Amendment (SPA) Transmittal Number 10-017

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 10-017. This SPA amends the amount, duration, and scope of certain services currently covered in the Basic (BBBP), Enhanced (EBBP), and Medicare/Medicaid Coordinated (MMCBBP) Benchmark Benefit Plans pursuant to legislative priorities for cost reductions (HB 701).

During the review of Idaho SPA 10-017, CMS performed analyses of Independent School District Services and Developmental Disability Agency Services. These analyses revealed issues that will require additional information and/or possible revision through a corrective action plan (CAP). Under separate cover, CMS will release a letter detailing those issues, and provide guidance on timeframes for correction.

This SPA is approved effective January 1, 2011, as requested by the State.

If you have additional questions or require further assistance, please contact me, or have your staff contact Jan Mertel at (206) 615-2317 or via email at Jan.Mertel@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Leslie Clement, Administrator, Idaho Department of Health and Welfare
Paul Leary, Deputy Administrator, Idaho Department of Health and Welfare

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 10-017

2. STATE: IDAHO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **January 1, 2011**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1937 of the Social Security Act; Section 1905 (a) of the Social Security Act; Section 1932 of the Social Security Act and 42 CFR440.169

7. FEDERAL BUDGET IMPACT:
~~FFY 2012 ($11,905,221.88)~~
FFY 2011 ($11,539,077) (P+I)
FFY 2012 ($15,305,352) (P+I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Attachment 3.1-E, page 12.~~ (P+I)
Attachment 3.1-C, Basic Benchmark Benefit, pages 32 and 33.
Attachment 3.1-C, Enhanced Benchmark Benefit, pages 30, 31, 31a, 39, 40, 41, 43, 49, 49f, 49h (removing pages 47, 47a, 47b, 47c, 47d)
Attachment 3.1-C, Medicare/Medicaid Coordinated Plan, pages 15 and 15a.
Attachment 4.19-B, pages 1, 21, 23c and 43. (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Attachment 3.1-E, page 12.~~ (P+I)
Attachment 3.1-C, Basic Benchmark Benefit, pages 32 and 33.
Attachment 3.1-C, Enhanced Benchmark Benefit, pages 30, 31, 31a, 39, 40, 41, 43, 47, 47a, 47b, 47c, 47d, 49, 49f, 49h.
Attachment 3.1-C, Medicare/Medicaid Coordinated Plan, pages 15 and 15a.
Attachment 4.19-B, pages 1, 21, 23c and 43. (P+I)

10. SUBJECT OF AMENDMENT:
HB701 of the 2010 Idaho Legislative Session directed the Department of Health and Welfare , Division of Medicaid, to make benefit modifications in order to maintain lower costs, but still provide accessible and substantially similar Medicaid benefits. As a result of this directive. Division of Medicaid met with stakeholders to identify potential cost savings measures. The requested amendments reflect the input of stakeholders and are intended to align with legislative direction while maintaining a viable, more cost-effective Medicaid program.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
LESLIE M. CLEMENT

14. TITLE:
Administrator

15. DATE SUBMITTED: 11/23/10

16. RETURN TO:
Leslie M. Clement, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: NOV 24 2010

18. DATE APPROVED: JUN 06 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Carol J.C. Beverly

22. TITLE: Associate Regional Administrator
Division of Medicaid &
Children's Health

23. REMARKS:
Pen and ink changes authorized by the State on 1/14/2011.
Pen and ink changes authorized by the State on 3/31/2011.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent. Limit of one refitting, repair or additional parts in a calendar year.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.P VISION SERVICES

The Basic Benchmark Benefit Package includes **Vision Services** permitted under sections 1905(a)(5), 1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

Vision Screening. The Department will provide vision-screening services according to the recommended guidelines of the American Academy of Pediatrics. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens; the vision is considered part of the medical screening service, (i.e. eye chart).

The Department will pay for the following vision services and supplies.

- **Eye Examination.** The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period for each eligible participant to determine the need for glasses to correct or treat refractive error. The participant may receive more frequent eye examinations if:
  - The participant experiences a significant vision change.
  - There is a medically necessary reason for the exam such as a foreign body in the eye, redness, etc.
- **Eyeglasses.** Eligible participants who have been diagnosed with a visual defect and who need eyeglasses for correction of a refractive error, can receive one (1) pair of single vision or bifocal eyeglasses every four (4) years. Frames or lenses may be provided more frequently when:
  - There is a major visual change of plus or minus one-half (0.5) diopter of correction, replacement lenses will be provided.
  - There has been a major change in visual acuity documented by the physician and/or optometrist; and the necessary new lenses cannot be accommodated in the participant's existing frames, new frames will be provided.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

- Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department.
- Contact lenses will be covered only when there is documentation showing that the participant has an extreme condition precluding the use of conventional lenses including:
  - An extreme myopic condition requiring a correction equal to or greater than plus or minus ten (10) diopters,
  - Cataract surgery,
  - Keratoconus,
  - Anisometropia, or
  - Other extreme medical condition precluding the use of conventional lenses.
- Broken, lost, or missing glasses will not be repaired or replaced by the Department for individuals over the age of twenty (20).

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Selective Contract. The Department requires recipients to obtain eyeglasses only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services

The State assures it will comply with 42CFR 431.54 as it relates to this fee-for-service selective contracting system.

3.Q DENTAL SERVICES

3.Q.1 Medical and Surgical Services

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

The Basic Benchmark Benefit Package includes Medical and Surgical Services furnished by a dentist permitted under sections 1905(a)(5)(B), and 2110(a)(17) of the Social Security Act (in accordance with section 1905(a)(5)(B) of the Act) are covered for treatment of medical and surgical dental conditions when furnished by a licensed dentist subject to the

Skilled care facility services for individuals age 65 or older in institutions for mental diseases include services provided under the direction of a physician for the care of recipients who do not require hospital care, but whose mental or physical condition requires services that are above the level of both room and board and can be made available only through institutional facilities.

Intermediate care facility services for individuals age 65 or older in institutions for mental diseases include services provided under the direction of a physician for the care and treatment of recipients who do not require hospital or skilled nursing care, but whose mental or physical condition requires services that are above the level of both room and board and can be made available only through institutional facilities.

Inpatient psychiatric facility services for individuals under 22 years of age include services provided which meet medical necessity criteria determined by the Department or its authorized agent and provided in a JCAHO accredited hospital.

3.K.2 Outpatient Mental Health Services

Mental Health Clinics. MH Clinic services are services that evaluate the need for and provide preventative, therapeutic, rehabilitative treatment to minimize psychiatric symptoms and enhance independent functioning. These services include:

- Evaluation and diagnostics (includes comprehensive diagnostic assessments and occupational therapy assessments)
- Psychosocial and neuropsychological testing
- Psychotherapy
- Pharmacological management
- Partial care
- Nursing
- Occupational therapy

These services must be furnished by or under the direction of a physician.

Provider Qualifications. MH Clinic Services can be provided by Clinics that are under the direction of a physician. Licensed, qualified professionals providing Outpatient Mental Health services must have at a minimum, one of the following qualifications:

- Psychiatrist
- Physician or practitioner of the Healing Arts
- Psychologist or psychologist extender
- Social Worker (Masters, Clinical, Licensed)
- Counselor (Clinical Professional, Professional)
- Marriage and Family Therapist (Associate Marriage and Family Therapist
- Certified Psychiatric Nurse
- Professional Nurse (RN)
- Occupational Therapist

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State Plan, unless otherwise authorized by the Department.

- Individual, family and group psychotherapy services are limited to a maximum of forty-five (45) hours in a calendar year.
- A combination of any evaluative or diagnostic services is limited to four (4) hours in a calendar year.
- Psychological and neuropsychological testing services are limited to two (2) computer-administered testing sessions and four (4) assessment hours per calendar year.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Partial Care Services. Partial care is defined as "treatment for participants with severe and persistent mental illness whose functioning is sufficiently disrupted so as to interfere with their productive involvement in daily living. Partial care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition."

Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the following qualifications:

- Licensed Psychiatrist
- Licensed Physician or Licensed Practitioner of the Healing Arts
- Licensed Psychologist
- Psychologist Extender, registered with the Bureau of Occupational Licenses
- Licensed Masters Social Worker
- Licensed Clinical Social Worker
- Licensed Social Worker
- Licensed Clinical Professional
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist
- Licensed Associate Marriage and Family Therapist
- Certified Psychiatric Nurse, RN
- Licensed Professional Nurse, RN
- Registered Occupational Therapist, OTR

Partial care treatment will be limited to twelve (12) hours per week, per eligible recipient.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.K.3 **Psychosocial Rehabilitative Services (PSR)**

Psychosocial Rehabilitation (PSR) services. PSR services are services provided to reduce to a minimum a participant's mental disability and restore the participant to the highest possible functional level within the community by the use of skill building tasks and the encouragement of more independent functioning. These services include:

- Evaluation and diagnostic services
- Psychological and neuropsychological testing
- Individual, group and family psychotherapy services
- Community crisis support services
- Individual and group skill training or community reintegration services

Provider Qualifications. PSR services can be provided by agencies who employ licensed, qualified professionals who must have at a minimum, one of the following qualifications:

- Psychiatrist
- Physician or practitioner of the healing arts
- Psychologist or psychologist extender
- Social Worker (Masters, Clinical, Licensed)
- Clinical Professional Counselor
- Professional Counselor
- Marriage & Family Therapist (Associate Marriage & Family Therapist)
- Certified psychiatric nurse
- Professional Nurse (RN)
- Occupational Therapist
- PSR Specialist - must have a BA as listed in Dept. rule. PSR specialists are not licensed; they are required to obtain PSR Specialist Certification in accordance with USPRA requirements by 2012. Reference IDAPA 16.03.10.131.03.

Limitations. The following service limitations apply to The Enhanced Benchmark Benefit Package covered under the State Plan, unless otherwise authorized by the Department:

- A combination of any evaluation or diagnostic services is limited to a maximum of four (4) hours in a calendar year.
- Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours in a calendar year.
- Community crisis support services are limited to a maximum of seven (7) consecutive days and must receive prior authorization from the Department.
- Individual and group skill training or community reintegration services are limited five (5) hours per week in any combination.
- Psychological and neuropsychological testing services are limited to two (2) computer administered testing sessions and four (4) assessments per calendar year.

Excluded services. The following services are not covered as a PSR Service:

Treatment services rendered to recipients residing in inpatient medical facilities including nursing facilities or hospitals

Recreational therapy and activities that are primarily recreational or social in nature

Employment/job specific interventions, job training, job placement, job coaching

Staff performance of household tasks or medication drops

Treatment of other individuals (such as family members)

Services that are primarily available through service coordination (case management)

Transportation

Services to an inmate of a public institution

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Specialized Medical Equipment and Supplies are also covered for certain participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.O.3 Prosthetic Devices

The Enhanced Benchmark Benefit Package includes **Prosthetic Devices** permitted under sections 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

The Department will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent. Limit of one refitting, repair or additional parts in a calendar year.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.P VISION SERVICES

The Enhanced Benchmark Benefit Package includes **Vision Services** permitted under sections 1905(a)(6), 1905(a)(5), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

Screening: The Department will provide vision-screening services according to the recommended guidelines of the American Academy of Pediatrics. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens; the vision is considered part of the medical screening service, (i.e. eye chart).

The Department will pay for the following vision services and supplies:

- Eye Examination: The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period for each eligible participant to determine the need for glasses to correct or treat refractive error. The participant may receive more frequent eye examinations if:
  - The participant experiences a major vision change.
  - There is a medically necessary reason for the exam such as a foreign body in the eye, redness, or other medical condition.

Eyeglasses. Eligible participants who have been diagnosed with a visual defect and who need eyeglasses to correct a refractive error, can receive one (1) pair of single vision or bifocal eyeglasses once every four year. Services may be provided more frequently in the following cases:

- If there is a major visual change of plus or minus one-half (0.5) diopters of correction, the Department can authorize purchase of a second pair of lenses.
- If the medically necessary new lenses cannot be accommodated in the participant's existing frames, new frames may be covered.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under this State plan..

- Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department.
- Contact lenses will be covered only when there is documentation showing that the participant has an extreme condition precluding the use of conventional lenses including:
  - An extreme myopic condition requiring a correction equal to or greater than plus or minus ten (10) diopters,
  - Cataract surgery,
  - Keratoconus,
  - Anisometropia, or
  - Other extreme medical condition that precludes the use of conventional lenses.
- Broken, lost, or missing glasses will not be replaced by the Department, and are the responsibility of the participant.

Selective Contract. The Department requires recipients to obtain eyeglasses only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42CFR 431.54 as it relates to this fee-for-service selective contracting system.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.Q DENTAL SERVICES

3.Q.1 Medical and Surgical Services

The Enhanced Benchmark Benefit Package includes **Medical and Surgical Services** furnished by a dentist permitted under sections 1905(a)(5)(B)and 2110(a)(17) of the Social Security Act (in accordance with section 1905(a)(5)(B) of the Act) are covered for treatment of medical and surgical dental conditions when furnished by a licensed dentist subject to the limitations of practice imposed by state law, and according to applicable Department rules.

Dentures are covered as specified in applicable Department rules.

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Elective medical and surgical dental services are excluded from payment unless prior approved by the Department or its authorized agent. All hospitalizations for dental care must be prior approved by the Department or its authorized agent.

Excluded Services. The following services are excluded from the Enhanced Benchmark Benefit Package covered under the State plan.

Non-medically necessary cosmetic services are excluded from payment. Drugs supplied to patients for self-administration other than those allowed by applicable Department rules are excluded from payment.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.Q.2 Other Dental Care

qualified providers.

3.R.4 Independent Schools District Services

Independent School Districts which have entered into a provider agreement with the Department may bill for the following Basic and Enhanced Plan Services when they are identified on the student's Individual Education Plan (IEP). All provider qualification and prior authorization requirements as specified in IDAPA 16.03.09 for these services apply.

Covered Services.

Medical Equipment and Supplies - Medical equipment and supplies as allowed under 440.70 that are covered by Medicaid and are needed for use at school but are too large or unsanitary to transport from home to school. They must be for the student's exclusive use and transfer with the student if the student changes schools.

Nursing Services - Skilled nursing services that must be provided by a licensed nurse. Emergency, first aide or assistance with non-routine medications not identified on the IEP as a health related service are not reimbursable.

Occupational Therapy and Evaluation - Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation is not covered.

Personal Care Services - School based personal care services include medically orientated tasks having to do with the student's physical or functional requirements while at school.

Physical Therapy and Evaluation

Psychotherapy

Psychosocial Rehabilitation and Evaluation - Services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills and coping skills.

Intensive Behavioral Intervention - Short term, one on one comprehensive interventions that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills.

Speech/Audiological Therapy and Evaluation

Social History and Evaluation

Transportation - Student must require special transportation that is ordered by a physician and included on the IEP, and receive another Medicaid reimbursable service on the same day.

Interpretative Services - may only be billed when a student needs the service of an interpreter to receive a Medicaid reimbursable service. Not covered if the person providing the service is able to communicate in the student's primary language.

Limitations.

School Districts are subject to the limitations for covered services. Services provided by schools do not count toward the limitations for other service providers. Services beyond the scope of service limitation must be identified in an EPSDT screen, found to be medically necessary and prior authorized.

Excluded Services: Vocational, Education and Recreational services are not reimbursable under the Benchmark Plans.

3.S MEDICAL TRANSPORTATION SERVICES

The Enhanced Benchmark Benefit Package includes **Medical**

~ BREAK IN PAGE NUMBER ~

there of) for the mentally retarded or persons with related conditions.

3.V.2 **Developmental Disability Agency Services**

The Enhanced Benchmark Benefit Package also includes rehabilitation services permitted under section 1905(a) of the Social Security Act which are the core medical rehabilitative services to be provided on a statewide basis by facilities which have entered into a provider agreement with the Department and are licensed as Developmental Disability Agencies (DDAs) by the Department. Services provided by DDAs are outlined in the applicable Department rules.

A Developmental Disability Agency (DDA) is an agency that is a developmental disabilities facility, certified by the Department to provide services to people with developmental disabilities, and primarily organized and operated to provide therapy to individuals with developmental disabilities. An individual receiving service in a DDA must be determined to have developmental disabilities. Through qualified staff or contractors, a developmental disabilities agency provides the following services called developmental disabilities agency services: Developmental Therapy, Intensive Behavioral Intervention (IBI), IBI consultation, psychotherapy, speech language pathology, physical therapy, occupational therapy, and pharmacological management.

Intensive Behavioral Interventions (IBI).
EPSDT Rehabilitation Intensive Behavioral Interventions (IBI).
Pursuant to 42 CFR 440.230, Idaho has defined the amount, scope and duration of the EPSDT benefit of Intensive Behavioral Intervention (IBI) as follows: IBI is an individualized comprehensive, proven intervention used on a short term, one-to-one basis that produces measurable outcomes which diminish behaviors interfering with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. It is available only to children birth through age twenty-one (21) who have demonstrated self injurious, aggressive, or severely maladaptive behavior and severe deficits in the areas of verbal and non-verbal communication; or social interaction; or leisure and play skills.

IBI is available Statewide through developmental disabilities agencies, Idaho public school districts, charter schools, and Idaho Infant toddler programs. IBI services cannot exceed twenty-two (22) hours per week in combination with developmental therapy and occupational therapy in a DDA. IBI services are designed to be provided for up to a three (3) year duration by Developmental Disabilities Agencies.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Pharmacological Management by a DDA:

- Pharmacological management is consultation for the purpose of prescribing, monitoring or administering medications, provided by a physician or other practitioner of the healing arts in direct face to face contact with the participant and provided in accordance with the plan of service.

Qualifications for providers of Pharmacological Management by a DDA

- The professional must be either employed by a DDA or contracted by the DDA to provide pharmacological management services.
- Must be provided by a licensed physician or other licensed practitioner of the healing arts in direct face to face contact with the participant

Speech, Physical and Occupational Therapy by a DDA

Pursuant to 42 CFR 440.110, Idaho offers speech language pathology, physical therapy, and occupational therapy. The provider qualifications for these services are as follows:

A. Speech therapy (42 CFR 440.110 c)

Qualifications for providers of Speech Language Pathology by a DDA

A person licensed to conduct speech and hearing services by Idaho Code, who possesses a certificate of clinical competence in speech-language pathology from the American Speech Language and Hearing Association or who will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification.

- Provide services based on results of a speech and language assessment completed in accordance with IDAPA.

- Employed by a DDA or contracted by the DDA to provide speech language pathology services.

ENHANCED PLAN
(For Individuals with Disabilities, Including Elders, or Special Health Needs)
BENCHMARK BENEFIT PACKAGE

Limitations. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State plan.

Evaluation and Diagnostic services provided by Developmental Disabilities Agencies are limited to four (4) hours reimbursable time allowed for the combination of all evaluations or diagnostic services; limit of a maximum of twenty-two (22) hours per week of developmental disabilities agency services.

Psychological testing by a DDA is limited to two (2) computerized testing sessions and four (4) assessment hours per calendar year.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

3.K.2 Outpatient Mental Health Services (Medicare Advantage Plan)

Mental Health Clinics. MH Clinic services are services that evaluate the need for and provide preventative, therapeutic, rehabilitative treatment to minimize psychiatric symptoms and enhance independent functioning. Mental Health Clinic services must be provided by or under the direction of a physician.

Mental Health Clinic services are limited to the scope of services as defined by the individual Medicare Advantage Plan.

Mental Health Clinic services are subject to the provider qualifications as defined by the individual Medicare Advantage Plan.

Mental Health Clinic services are subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.K.3 Psychosocial Rehabilitative Services (PSR) (Medicaid Providers)

Psychosocial Rehabilitation (PSR) services. PSR services are services provided to reduce to a minimum a participant's mental disability and restore the participant to the highest possible functional level within the community by the use of skill building tasks and the encouragement of more independent functioning. These services include:

- Evaluation and diagnostic services
- Psychological and neuropsychological testing
- Individual, group and family psychotherapy services
- Community crisis support services Individual and group skill training or community reintegration services

Provider Qualifications. PSR services can be provided by agencies who employ licensed, qualified professionals who must have at a minimum, one of the following qualifications:

- Psychiatrist
- Physician or practitioner of the healing arts
- Psychologist or psychologist extender
- Social Worker (Masters, Clinical, Licensed)
- Clinical Professional Counselor
- Professional Counselor
- Marriage & Family Therapist (Associate Marriage & Family Therapist)
- Certified psychiatric nurse
- Professional Nurse (RN)
- Occupational Therapist
- PSR Specialist - must have a bachelor's degree as listed in Department rule. PSR Specialists are not licensed; they are required by Department rule to obtain PSR Specialist Certification, in accordance with USPRA requirements, by 2012. Reference IDAPA 16.03.10.131.03.

Limitations. The following service limitations apply to The Medicare-Medicaid Coordinated Benchmark Benefit Package covered under the State Plan, unless otherwise authorized by the Department:

- A combination of evaluation or diagnostic services is limited to a maximum of four (4) hours in a calendar year.
- Psychological and neuropsychological are limited to two (2) computer-administered testing sessions and four (4) assessment hours for eligible participants per calendar year. Additional testing must be prior authorized by the Department.
- Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours in a calendar year.
- Community crisis support services are limited to a maximum of seven (7) consecutive days and must receive prior authorization from the Department.

- Individual and group skill training or community reintegration services are limited to five (5) hours per week in any combination.

Excluded services. The following services are excluded PRS services:

- Treatment services rendered to recipients residing in inpatient medical facilities including nursing facilities or hospitals
- Recreational therapy and activities that are primarily recreational or social in nature
- Employment/job specific interventions, job training, job placement, job coaching
- Staff performance of household tasks or medication drops
- Treatment of other individuals (such as family members)
- Services that are primarily available through service coordination (case management)
- Transportation
- Services to an inmate of a public institution

9. a. Clinic Services

i. Mental Health Clinics — The Department's medical assistance upper limit for reimbursement is the lower of: the mental health clinic's actual charge; or the allowable charge as established by the Department's medical assistance fee schedule. Mental health clinic reimbursement is subject to the provisions of 42 CFR 447.321.

"Clinic Services" are described in Idaho's Basic Benchmark Benefit Package in Sections 3.B.2., and 3.K.2., and in Idaho's Enhanced Benchmark Benefit Plan in Sections 3.B.2., and 3.K.2.

Rate(s):

For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule.

For other health professional authorized to administer mental health services, the statewide reimbursement rate for mental health services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment related expenditures and indirect general and administrative costs which includes program related costs and are based on surveyed data.

Reimbursement rates for these services are set at a percentage of the statewide target reimbursement rate described above. The following CPT codes represent the service codes paid to mental health clinic service providers who are considered other health professionals authorized to administer mental health clinic services:

Code	Description	Rate of Reimbursement
H2014	Partial Care (per 15 min.)	$2.24

The fee schedule for the above listed codes and any annual/periodic adjustments to the fee schedule for the above listed codes are published at the following web site:

http://www.healthandwelfare.idaho.gov

The fee schedule will be effective for services on or after 1/1/2011.

The agency's rates are set from 07/01/2008 on and are effective for services on or after that date. All rates are published on the rehab mental health codes fee schedule at the agency's web site:

http://www.healthandwelfare.idaho.gov

For other health professionals authorized to administer rehabilitative mental health services, the statewide target reimbursement rate for rehabilitative mental health services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment related expenditures and indirect general and administrative costs, which includes program related costs and are based on surveyed data.

Reimbursement rates for these services are set at a percentage of the statewide target reimbursement rate described above. The following CPT codes represent the service codes paid to rehabilitative mental health service providers who are considered other health professionals authorized to administer rehabilitative mental health services:

Code	Description	Rate of Reimbursement
H2014	Group Skill Training (per 15 min.)	$2.77
H2017	Individual Skill Training (per 15 min.)	$11.35
H0036	Community Reintegration (per 15 min.)	$11.35

The agency's rates are set from 1-1-2011on and are effective for services on or after that date.

"Rehabilitation Services" are described in Idaho's Basic Benchmark Benefit Package in Section 3.K and 3.M, and in Idaho's Enhanced Benchmark Benefit Plan in Section 3.K and 3.M.

14. Services for individuals age 65 or older in institutions for mental diseases.

b. & c. Skilled Nursing Facility Services – Refer to Attachment 4.19-D.

a. & b. Intermediate Care Facilities for the Mentally Retarded - Refer to Attachment 4.19-D

"Services for Individuals Age 65 or Older in Institutions for Mental Diseases" are described in Idaho's Basic Benchmark Benefit Package in Section 3.K.1., and in Idaho's Enhanced Benchmark Benefit Plan in Section 3.K.1.

29. Developmental Disability Services - The rate of reimbursement for each component of ambulatory services included in the State's Medicaid Plan will be established by the Department's Medical Assistance Unit. This reimbursement rate will not exceed the usual and customary charges for comparable services under comparable circumstances in public and private agencies in the State of Idaho.

Rate(s):

For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's Medical Assistance fee schedule.

For other health professional authorized to administer developmental disability services, the statewide reimbursement rate for developmental disability services was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment related expenditures and indirect general and administrative costs which includes program related costs and are based on surveyed data.

Reimbursement rates for these services is set at a percentage of the statewide target reimbursement rate described above. The following CPT codes represent the service codes paid to developmental disability service providers who are considered other health professionals authorized to administer developmental disability services:

Code	Modifier	Description	Rate of Reimbursement
97537		Development Therapy in Home or Community – Individual (per 15 min.)	$5.01
97537	HQ	Development Therapy in Home or Community – Group (per 15 min.)	$2.14
H0024		Intense Behavioral Intervention Consultation (per 15 min.)	$11.35
H2000		Developmental Disability Evaluation (per 15 min.)	$4.53
H2014	HQ	Children's or NF Developmental Disability in the Center – Group (per 15 min.)	$1.80
H2014		Children's or NF Developmental Disability in the Center – Individual (per 15 min.)	$5.01
H2019		Intense Behavioral Intervention – Professional (per 15 min.)	$11.35
H2019	HM	Intense Behavioral Intervention – Paraprofessional (per 15 min.)	$5.10
H2021	HQ	Children Development Therapy in the Community – Group (per 15 min.)	$2.14
H2021		Children Development Therapy in the Community – Individual (per 15 min.)	$5.01
H2032		Development Therapy in Center - Individual (per 15 min.)	$4.53
H2032	HQ	Development Therapy in Center – Group (per 15 min.)	$1.80
T1028		Social History and Evaluation (per 15 min.)	$9.94
T2024		Comprehensive Intense Behavioral Intervention Assessment (per 15 min.)	$11.35

The fee schedule for the above listed codes and any annual/periodic adjustments to the fee schedule for the above listed codes are published at the following web site: http://www.healthandwelfare.idaho.gov

The fee schedule will be effective for services on or after 1/1/2011.