Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.

Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

3.K MENTAL HEALTH SERVICES

3.K.1 Inpatient Psychiatric Services

In addition to Psychiatric Services covered under Inpatient Hospital Services, the Basic Benchmark Benefit Package Medical Assistance includes services **for Certain Individuals in Institutions for Mental Diseases** permitted under sections 1905(a)(14) of the Social Security Act.

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.

Limitations. Inpatient mental health services, including Psychiatric Services covered under Inpatient Hospital Services, are limited to ten (10) days per calendar year.

3.K.2 Community-Based Outpatient Behavioral Health Services

Community-Based Outpatient Behavioral Health Services. Behavioral health services are medically necessary rehabilitation services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. These services include:

Screening, Evaluation and Diagnostic Assessments (includes occupational therapy assessments). Assessment and evaluation define or delineate the individual's mental health/substance use disorder diagnoses and related service needs. Assessment and evaluation services are used to document the nature of the individual's behavioral health status in terms of interpersonal, situational, social, familial, economic, psychological, substance abuse and other related factors. These services include at least two major components: 1) screening and evaluation (including medical, bio-psychosocial history; home, family, and work environment assessment; and physical and laboratory studies/testing and psychological testing as appropriate); and 2) a written report on the evaluation results to impart the evaluator's professional judgment as to the nature, degree of severity, social-psychological functioning, and recommendations for treatment alternatives.

Treatment Planning. The treatment plan refers to a written document that outlines the prescribed treatment for the individual using multidisciplinary assessment and evaluation documentation completed and gathered. The treatment plan is updated to reflect the progression of therapy.

Psychological and Neuropsychological Testing.

o Psychological Testing refers to any measurement procedure for assessing psychological characteristics where a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process.

o Neuropsychological Testing involves an assessment of brain functioning through structured and systematic behavioral observation. Neurological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory, language, and executive functions, which are necessary for goal-directed behavior.

Psychotherapy (Individual, Group and Family).

o **Individual**. Individual counseling consists of various evidence-based professional rehabilitative therapeutic interventions and is used to address an individual's alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, connecting with and utilizing natural supports, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various community-based settings.

o **Group.** Group psychotherapy consists of rehabilitative therapeutic interventions provided to Medicaid eligible children, adolescents or adults to address an individual's alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various settings. Group size should be at least three or more, but fewer than 10 individuals.

o **Family Psychotherapy.** Evidence-based rehabilitative Interventions directed toward an individual and family to address emotional or cognitive problems which may be causative/exacerbating of the primary mental disorder or have been triggered by the stress related to coping with mental and physical illness, alcohol and drug abuse, and psychosocial dysfunction. Personal trauma, family conflicts, family dysfunction, self-concept responses to medication, and other life adjustments reflect a few of the issues that may be addressed. The State Plan service allows for any combination of family members, whether just adults or adults with children/adolescents.

Pharmacologic Management. Medication management is a pharmacotherapy service provided by a psychiatrist, physician or other individual licensed to prescribe medications to assess and evaluate the individual's presenting conditions and symptoms, medical status, medication needs and/or substance abuse status. This includes evaluating the necessity of pharmacotherapy or other alternative treatments, prescribing, preparing, dispensing, and administering oral or injectable medication. Informed consent must be obtained for each medication prescribed.

Partial Care Treatment. A distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care that is reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or reduce disability or restore the individual's condition and functional level and to prevent relapse or hospitalization.

Behavioral Health Nursing. Professional services directed at the reduction of disability or restoration of functioning related to a Member's mental health problems and the care and treatment of persons with behavioral health disorders.

Occupational Therapy. For the purposes of mental health treatment, the use of purposeful, goal-oriented activity to achieve optimum functional performance and independence, prevent further disability, and maintain health with individuals who are limited by the symptoms of their mental illness.

Drug Screening. Laboratory screenings are used to treat behavioral health and medical disorders and provide pharmacologic management. Tests may include, but are not limited to: urinalysis, other formal drug screenings and blood tests.

Community-Based Rehabilitation and Substance Use Disorder Treatment Services. These services consist of community-based evidence-based practices that are restorative interventions or interventions that reduce disability and that are provided to Members with serious, disabling mental illness or substance use disorders for the purpose of increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology or eliminating or reducing alcohol and drug use and implementing structure and support to achieve and sustain recovery, and ensuring a satisfactory quality of life. Services include treatment planning, and the provision and coordination of treatments and services delivered by multidisciplinary teams under the supervision of a licensed behavioral health professional staff, physician or nurse.

- Interventions for psychiatric symptomatology will use an active, assertive outreach approach and including use of a comprehensive assessment and the development of a community support treatment plan, ongoing monitoring and support, medication management, skill restoration, crisis resolution and accessing needed community resources and supports.
- Interventions for substance use disorders, will include substance use disorder treatment planning, psycho-education and supportive counseling which are provided to achieve rehabilitation and sustain recovery and restoration of skills needed to access needed community resources and supports. These services are provided in conjunction with any professional or therapeutic behavioral health services identified as necessary for the member.

Case Management. For case management please refer to section 3.K.4 of the Basic Benchmark State Plan.

Prepaid Ambulatory Health Plan (PAHP). Pursuant to 1915(b) of the Social Security Act, the Department requires recipients to obtain all community-based outpatient behavioral health services, through a statewide PAHP. Community-based outpatient behavioral health services are provided by providers who undertake to provide such services with the PAHP Contractor 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 42 CFR 438 as it relates to this prepaid ambulatory health plan contracting system for community-based outpatient behavioral health services.

Limitations. All community-based outpatient behavioral health services are subject to the limitation of practice imposed by state law, federal regulations and according to applicable Department Rules, the PAHP contract as awarded or amended and approved by the Department or its authorized agent based upon medical necessity.

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

Excluded Services. Experimental or Non-medically necessary services as determined by the Department or its authorized agent will be excluded.

Minimum Provider Qualifications.

Each community-based outpatient behavioral health benefit outlined in the matrix below, is provided by a PAHP contracted and qualified provider as established by the contract, and set forth below for minimum provider qualifications.

All community-based outpatient behavioral health services providers are subject to the limitations of practice imposed by State Law, Federal Regulations, The State of Idaho Occupational Licensing's requirements, the providers professional area of competency and as according to applicable Department Rules, approval by the Department, and its Pre-paid Ambulatory Health Plan (PAHP) Contractor as established in the Contract.

Matrix of Minimum Provider Qualifications for Idaho Medicaid Behavioral Health PAHP									
		Provider Types							
		PAHP Contracted: Licensed Physician, Licensed Psychiatrist, Licensed Practitioner of the Healing Arts (Advanced Practice Nurse, Nurse Practitioner, Physician Assistant)	PAHP Contracted: Lic. Prof. Nurse, RN; Cert. Psychiatric Nurse, RN; Lic. Prof. Nurse, RN	PAHP Contracted: Licensed Social Worker	PAHP Contracted: Licensed Counselor	PAHP Contracted : Licensed Psychologist, Psychologist Extender- (Registered with the Idaho Bureau of Occupational Licenses)	PAHP Contracted: Licensed Marriage and Family Therapist	PAHP Contracted Providers who: Hold at least a Bachelors degree and a Certification or Licensing in their field and meet requirements of Idaho Department of Health and Welfare or its Contractor.	PAHP Contracted Licensed Registered Occupational Therapist
Benefits	Assessment	X	X	X	X	X	X		X
	Multi-disciplinary Treatment planning	X	X	X	X	X	X	X	X
	Pharmacological Management	X	X						
	Psychotherapy	X	X	X	X	X	X		
	Psychological Testing	X	X	X	X	X	X		
	Occupational Therapy								X
	Rehabilitation Services	X	X	X	X	X	X	X	X
	Partial Care	X	X	X	X	X	X		X
	Drug Screening	X	X						
	Nursing Services		X						
	Community Crisis Intervention	X	X	X	X	X	X	X	X
	Case Management	X	X	X	X	X	X	X	X

3.K.4 Behavioral Health Case Management Services: Idaho Behavioral Health Plan

The Basic Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

The target group consists of members of the Idaho Behavioral Health Plan who are:

1. Adults age 18 and older with serious and persistent mental illness or other behavioral health diagnosis; or;
2. Children up to age 21 with serious emotional disturbance or other behavioral health diagnosis, and;
3. Who demonstrate medical necessity for case management services and require and choose assistance to access services and supports necessary to maintain independence in the community.

For case management services provided to individuals in medical institutions: [Olmstead letter #3]

☒ Target group is comprised of individuals transitioning to a community setting and case management services will be made available for up to the last 60 consecutive days of the covered stay in the medical institution.

Areas of State in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration and scope.

Definition of services: [DRA & 2001 SMD]
Behavioral Health Case Management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment and periodic reassessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:

Taking client history:
Identifying the individual's needs and completing related documentation;
Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

- Development (and periodic revision) of a specific care plan that:

Is based on the information collected through the assessment;
Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual; Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities:

To help an eligible individual obtain needed services including activities that help link an individual with:
Medical, social, educational providers; or Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

- Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
Services are being furnished in accordance with the individual's care plan;
Services in the care plan are adequate; and
If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.

- Case management may include:

Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of Providers:
The Targeted Case Management benefit is provided by a PAHP contracted and qualified provider as established by the contract, and set forth below for minimum provider qualifications. Service providers are subject to the limitations of practice imposed by State Law, Federal Regulations, The State of Idaho Occupational Licensing requirements, the provider's professional area of competency and as according to applicable Department Rules, approval by the Department and its Pre-paid Ambulatory Health Plan (PAHP) Contractor as established in the Contract.

- Minimum Provider Qualifications for Targeted Case Management Providers are PAHP contractors:
  Licensed Physician, Licensed Psychiatrist, Licensed Practitioner of the Healing Arts (Advanced Practice Nurse, Nurse Practitioner, Physician Assistant), Licensed Prof. Nurse, RN, Cert. Psychiatric Nurse, RN, Licensed Prof. Nurse, RN, Licensed Social Worker, Licensed Counselor, Licensed Psychologist, Psychologist Extender-(Registered with the Idaho Bureau of Occupational Licenses) Licensed Marriage and Family Therapist, Hold at least a Bachelor's degree and a Certification or Licensing in their field and meet requirements of Idaho Department of Health and Welfare or its Contractor, Licensed Registered Occupational Therapist.

Waiver of Freedom of Choice of Providers
As permitted and authorized under section 1915 (b) (4) of the Social Security Act, choice of targeted case management providers is waived. Behavioral Health targeted case management will be provided by the prepaid ambulatory health plan for the Idaho Behavioral Health Plan.

- Eligible recipients will have free choice of providers of other medical care under the state plan.

Freedom of Choice Exception (1915(g)(1) and 42 CFR 441.18(b):

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that:
Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]

Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]

Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42 CFR 431.10(e)

Payment (42 CFR 441.18(a)(4)):
Payment for case management or target case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
The State assures that providers maintain case records that document for all individuals receiving case management as follows [42 CFR 441.18(a)(7)]:
The name of the individual.
The dates of the case management services.
The name of the provider agency and the person providing the case the case management service
The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.
Whether the individuals has declined services in the care plan
The need for, and occurrences of, coordination with other case managers.
A timeline for obtaining needed services
A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

3.L HOME HEALTH CARE

The Basic Benchmark Benefit Package includes **Home Health Care Services** permitted under sections 1905(a)(7) and 1905(a)(8), of the Social Security Act.

The Basic Benchmark Benefit Package includes **Home Health Services** permitted under sections 1905(a)(7), of the Social Security Act.

These services include intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Services also include home health aide services provided by a home health agency.

Home health services are provided in accordance with the requirements of 42 CFR 441.15and 42 CFR 440.70.

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 Community-Based Outpatient Behavioral Health Services

Community-Based Outpatient Behavioral Health Services. Behavioral health services are medically necessary rehabilitation services that evaluate the need for and provide, therapeutic, and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. These services include:

Screening, Evaluation and Diagnostic Assessments (includes occupational therapy assessments). Assessment and evaluation define or delineate the individual's mental health/substance use disorder diagnoses and related service needs. Assessment and evaluation services are used to document the nature of the individual's behavioral health status in terms of interpersonal, situational, social, familial, economic, psychological, substance abuse and other related factors. These services include at least two major components: 1) screening and evaluation (including medical, bio-psychosocial history; home, family, and work environment assessment; and physical and laboratory studies/testing and psychological testing as appropriate); and 2) a written report on the evaluation results to impart the evaluator's professional judgment as to the nature, degree of severity, social-psychological functioning, and recommendations for treatment alternatives.

Treatment Planning. The treatment plan refers to a written document that outlines the prescribed treatment for the individual using multidisciplinary assessment and evaluation documentation completed and gathered. The treatment plan is updated to reflect the progression of therapy.

Psychological and Neuropsychological Testing.

o Psychological Testing refers to any measurement procedure for assessing psychological characteristics where a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process.

o Neuropsychological Testing involves an assessment of brain functioning through structured and systematic behavioral observation. Neurological tests are designed to examine a variety of cognitive abilities, including speed of information processing, attention, memory, language, and executive functions, which are necessary for goal-directed behavior.

Psychotherapy (Individual, Group and Family).

o **Individual**. Individual counseling consists of various evidence-based professional therapeutic interventions and is used to address an individual's alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, connecting with and utilizing natural supports, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various community-based settings.

o **Group.** Group psychotherapy consists of group therapeutic interventions provided to Medicaid eligible children, adolescents or adults to address an individual's alcohol or drug abuse and/or emotional, behavioral or cognitive problems. Personal trauma, family conflicts, responses to medication, and other life adjustments reflect a few of the many issues that may be addressed. Services may be provided in various settings. Group size should be at least three or more, but fewer than 10 individuals.

o **Family Psychotherapy.** Interventions directed toward an individual and family to address emotional or cognitive problems which may be causative/exacerbating of the primary mental disorder or have been triggered by the stress related to coping with mental and physical illness, alcohol and drug abuse, and psychosocial dysfunction. Personal trauma, family conflicts, family dysfunction, self-concept responses to medication, and other life adjustments reflect a few of the issues that may be addressed. The State Plan service allows for any combination of family members, whether just adults or adults with children/adolescents.

Pharmacologic Management. Medication management is a pharmacotherapy service provided by a psychiatrist, physician or other individual licensed to prescribe medications to assess and evaluate the individual's presenting conditions and symptoms, medical status, medication needs and/or substance abuse status. This includes evaluating the necessity of pharmacotherapy or other alternative treatments, prescribing, preparing, dispensing, and administering oral or injectable medication. Informed consent must be obtained for each medication prescribed.

Partial Care Treatment. A distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care that is reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or reduce disability or restore the individual's condition and functional level and to prevent relapse or hospitalization.

Behavioral Health Nursing. Professional services directed at the reduction of disability or restoration of functioning related to a Member's mental health problems and the care and treatment of persons with behavioral health disorders.

Occupational Therapy. For the purposes of mental health treatment, the use of purposeful, goal-oriented activity to achieve optimum functional performance and independence, prevent further disability, and maintain health with individuals who are limited by the symptoms of their mental illness.

Drug Screening. Laboratory screenings are used to treat behavioral health and medical disorders and provide pharmacologic management. Tests may include, but are not limited to: urinalysis, other formal drug screenings and blood tests.

Community-Based Rehabilitation and Substance Use Disorder Treatment Services. These services consist of community-based evidence-based practices that are restorative interventions or interventions that reduce disability and that are provided to Members with serious, disabling mental illness ,emotional disturbance or substance use disorders for the purpose of increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology or eliminating or reducing alcohol and drug use and implementing structure and support to achieve and sustain recovery, and ensuring a satisfactory quality of life. Services include treatment planning, and the provision and coordination of treatments and services delivered by multidisciplinary teams under the supervision of a licensed behavioral health professional staff, physician or nurse.

- Interventions for psychiatric symptomatology will use an active, assertive outreach approach and including use of a comprehensive assessment and the development of a community support treatment plan, ongoing monitoring and support, medication management, skill restoration, crisis resolution and accessing needed community resources and supports.
- Interventions for substance use disorders, will include substance use disorder treatment planning, psycho-education and supportive counseling which are provided to achieve rehabilitation and sustain recovery and restoration of skills needed to access needed community resources and supports. These services are provided in conjunction with any professional or therapeutic behavioral health services identified as necessary for the member.

Case Management. For case management please see section 3.K.4 of Enhanced Benchmark State Plan.

Prepaid Ambulatory Health Plan (PAHP). Pursuant to 1915(b) of the Social Security Act, the Department requires recipients to obtain all community-based outpatient behavioral health services, through a statewide PAHP. Community-based outpatient behavioral health services are provided by providers who undertake to provide such services with the PAHP Contractor 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 42 CFR 438 as it relates to this prepaid ambulatory health plan contracting system for community-based outpatient behavioral health services.

Limitations. All community-based outpatient behavioral health services are subject to the limitation of practice imposed by state law, federal regulations and according to applicable Department Rules, the PAHP contract as awarded or amended and approved by the Department or its authorized agent based upon medical necessity.

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

Excluded Services. Experimental or Non-medically necessary services as determined by the Department or its authorized agent will be excluded.

Minimum Provider Qualifications.

Each community-based outpatient behavioral health benefit outlined in the matrix below, is provided by a PAHP contracted and qualified provider as established by the contract, and set forth below for minimum provider qualifications.

All community-based outpatient behavioral health services providers are subject to the limitations of practice imposed by State Law, Federal Regulations, The State of Idaho Occupational Licensing's requirements, the providers professional area of competency and as according to applicable Department Rules, approval by the Department, and its Pre-paid Ambulatory Health Plan (PAHP) Contractor as established in the Contract.

Matrix of Minimum Provider Qualifications for Idaho Medicaid Behavioral Health PAHP									
		Provider Types							
		PAHP Contracted: Licensed Physician, Licensed Psychiatrist, Licensed Practitioner of the Healing Arts (Advanced Practice Nurse, Nurse Practitioner, Physician Assistant)	PAHP Contracted: Lic. Prof. Nurse, RN; Cert. Psychiatric Nurse, RN; Lic. Prof. Nurse, RN	PAHP Contracted: Licensed Social Worker	PAHP Contracted: Licensed Counselor	PAHP Contracted : Licensed Psychologist, Psychologist Extender- (Registered with the Idaho Bureau of Occupational Licenses)	PAHP Contracted: Licensed Marriage and Family Therapist	PAHP Contracted Providers who: Hold at least a Bachelor's Degree in a Human Services Field and a Certification or Licensing in their field and meet requirements of Idaho Department of Health and Welfare or its Contractor.	PAHP Contracted Licensed Registered Occupational Therapist
Benefits	Assessment	X	X	X	X	X	X		X
	Multi-disciplinary Treatment planning	X	X	X	X	X	X	X	X
	Pharmacological Management	X	X						
	Psychotherapy	X	X	X	X	X	X		
	Psychological Testing	X	X	X	X	X	X		
	Occupational Therapy								X
	Rehabilitation Services	X	X	X	X	X	X	X	X
	Partial Care	X	X	X	X	X	X		X
	Drug Screening	X	X						
	Nursing Services		X						
	Community Crisis Intervention	X	X	X	X	X	X	X	X
	Case Management	X	X	X	X	X	X	X	X

3.K.4 Case Management Services: Idaho Behavioral Health Plan

The Enhanced Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

The target group consists of members of the Idaho Behavioral Health Plan who are:

1. Adults age 18 and older with serious and persistent mental illness or other behavioral health diagnosis; or;
2. Children up to age 21 with serious emotional disturbance or other behavioral health diagnosis, and;
3. Who demonstrate medical necessity for case management services and require and choose assistance to access services and supports necessary to maintain independence in the community.

For case management services provided to individuals in medical institutions: [Olmstead letter #3]

☒ Target group is comprised of individuals transitioning to a community setting and case management services will be made available for up to the last 60 consecutive days of the covered stay in the medical institution.

Areas of State in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration and scope.

Definition of services: [DRA & 2001 SMD]

Behavioral Health case management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment and periodic reassessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:

Taking client history:
Identifying the individual's needs and completing related documentation;
Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:
Is based on the information collected through the assessment;
Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:
To help an eligible individual obtain needed services including activities that help link an individual with:
Medical, social, educational providers; or
Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:
Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities and contract may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met: services are being furnished in accordance with the individuals care plan; services in the care plan are adequate; and if there are changes in the needs or status of the individuals necessary adjustments are made to the care plan and service arrangements with the providers.

Case Management may include:
Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of Providers:
The targeted case management benefit is provided by a PAHP contracted and qualified provider as established by the contract, and set forth below for minimum provider qualifications. Service providers are subject to the limitations of practice imposed by State Law, Federal Regulations, The State of Idaho Occupational Licensing requirements, the provider's professional area of competency and as according to applicable Department Rules, approval by the Department and its Pre-paid ambulatory Health Plan Contractor as established by the Contract.

- Minimum Provider Qualifications for Targeted Case Management Providers are PAHP Contractors Holding at least a Bachelors' degree and a certification of Licensing in their field and meet requirements of Idaho Department of Health and Welfare or its Contractor.

Waiver of Freedom of Choice of Providers
As permitted and authorized under section 1915 (b) (4) of the Social Security Act, choice of targeted case management providers is waived. Behavioral Health targeted case management will be provided by the prepaid ambulatory health plan for the Idaho Behavioral Health Plan.

- Eligible recipients will have free choice of providers of other medical care under the state plan.

Freedom of Choice of Exception (1915(g)(1) and 42 CFR 441.18(b):
X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that:
Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]

Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]

Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42 CFR 431.10(e)

Payment (42 CFR 441.18(a)(4):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7):

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

- The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.
- Whether the individual has declined services in the care plan.
- The need for, and occurrences of, coordination with other case managers.
- A timeline for obtaining needed services.
- A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

3.V.4 Case Management Services: Adults with Developmental Disabilities

The Enhanced Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Target Group:

Adults age 18 and older, who have a developmental disability diagnosis, and who require and choose assistance to access services and supports necessary to maintain independence in the community.

For case management services provided to individuals in medical institutions: [Olmstead letter #3]

☒ Target group is comprised of individuals transitioning to a community setting and case management services will be made available for up to the last 60 consecutive days of the covered stay in the medical institution.

Areas of State in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Freedom of choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

- Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

☐ Target group consists of eligible individuals with developmental disabilities. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities receive needed services.

Access to Services:
The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]

- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42 CFR 431.10(e)

Payment (42 CFR 441.18(a)(4)):
Payment for case management or target case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7):
The State assures that providers maintain case records that document for all individuals receiving case management as follows [42 CFR 441.18(a)(7)]:

- The name of the individual.
- The dates of the case management services.
- The name of the provider agency and the person providing the case management service.

provided under EPSDT. Needs for services discovered during an EPSDT screening which are outside the coverage provided by applicable Department rules must be shown to be medically necessary and the least costly means of meeting the recipient's medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant. The Department will not cover services for cosmetic, convenience or comfort reasons. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in applicable Department rules specifically as a covered benefit or service will require preauthorization for medical necessity prior to payment for that service. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Enhanced Benchmark Benefit Package will not be subject to amount, scope, and duration limitations, but will be subject to prior-authorization. The additional service must be documented by the attending physician as medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department or its authorized agent will be required prior to payment.

Case Management Services: Children with Special Health Care Needs (SHCN).

The Enhanced Benchmark Benefit Package includes **Case Management Services** permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Target Group:

- Children up to age 21 who have special health care needs requiring medical and multidisciplinary rehabilitation services; and
- Who require and choose assistance to access services and supports necessary to maintain independence in the community.

For case management services provided to individuals in medical institutions: [Olmstead letter #3]

☒ Target group is comprised of individuals transitioning to a community setting and case management services will be made available for up to the last 60 consecutive days of the covered stay in the medical institution.

Areas of State in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Freedom of choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

- Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

☐ Target group consists of eligible individuals with developmental disabilities or children with special health care needs. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or children with special care health needs receive needed services.

Access to Services:
The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]

- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42 CFR 431.10(e)

Payment (42 CFR 441.18(a)(4)):
Payment for case management or target case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7):
The State assures that providers maintain case records that document for all individuals receiving case management as follows [42 CFR 441.18(a)(7)]:

- The name of the individual.
- The dates of the case management services.
- The name of the provider agency and the person providing the case management service.

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9. a. (Reserved for future use)

i.

The agency's rates are set from 07/01/2011 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 website:

http://www.healthandwelfare.idaho.gov

The Idaho Behavioral Health Plan. Effective July 1, 2013 the Department operates a contracted Behavioral Health System. The State assures it has established a community-based outpatient behavioral health program in order to more cost-effectively provide behavioral health services, and can document, upon request of CMS, that the behavioral health Contractor was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

The reimbursement for behavioral health services shall be by selective contract. Pursuant to Section 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d), the State assures that adequate services/devices shall be available under such arrangements.

The contracted community-based outpatient behavioral health services include:

- Screening, Evaluation and Diagnostic Assessments (includes occupational therapy assessments)
- Treatment Planning
- Psychological and Neuropsychological Testing
- Psychotherapy (Individual, Group, and Family)
- Pharmacologic Management
- Partial Care treatment
- Behavioral Health Nursing
- Occupational Therapy
- Drug Screening
- Community-based Rehabilitation Services
- Case management
- Community Crisis Intervention

The contractor will ensure the use of the most current and appropriate CPT and HCPC service codes within the array of services listed in accordance with the criteria established by the Current Procedural Terminology (CPT) manual issued by American Medical Association (AMA) and in compliance with the National Correct Coding Initiative.

"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

19. Case Management Services

Rate(s):

For adult participants with, Developmental Disabilities, and children up to age 21, who have special health care needs requiring medical and multidisciplinary rehabilitation services, one reimbursement rate will be paid for care plan development and case management services. The statewide reimbursement rate for a service coordinator and a paraprofessional was derived by using surveyed direct care staff data adjusted for employment related expenditures; non-productive time including vacation, sick time, and holiday; and an indirect general and administrative cost based on surveyed data.

The following CPT codes represent the case management service codes paid at the same rate:

Code	Description	Population
G9007	Plan Development	Developmentally Disabled
G9012	Plan Development	Children up to age 21
G9002	Targeted Service Coordination	Developmentally Disabled
G9002	Targeted Service Coordination	Children up to age 21
H2011	Community Crisis Support	Developmentally Disabled
H2011	Community Crisis Support	Children up to age 21

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 was last updated on 07/01/11 to be effective for services on or after 04/01/11.

The reimbursement for behavioral health services targeted case management shall be by selective contract. Pursuant to Section 1915 (a)(1)(B) of the Social Security Act and 42 CFR 431.54(d), the State assures that adequate services/devices shall be available under such arrangements.

For full-dual eligible only, those participants who have Medicare Part A, Medicare Part B, and Medicaid, "Case Management Services" are described in Idaho's Medicare-Medicaid Coordinated Benchmark Benefit Plan in Section 3.F.

Except as otherwise noted in the plan, State-developed fee schedules are the same for governmental and private providers of plan development, targeted service coordination, and community crisis support.

Unit Definition:

A unit of service is equivalent to fifteen (15) minutes. Minutes of service provided to a specific individual can be accrued over one calendar day. The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day for a specific individual divided by fifteen plus one additional unit if the remaining number of minutes is eight (8) or greater minutes.

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