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State/Territory Name Alaska

State Plan Amendment (SPA) #: 25-0005

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS Form 179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid
Services 601 E. 12th St., Room 355
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

October 14, 2025

Heidi Hedberg
Commissioner
Department of Health
3601 C Street, Suite 902
Anchorage, Alaska 99503-5923

Re: Alaska State Plan Amendment (SPA) 25-0005

Dear Commissioner Hedberg:

The Centers for Medicare & Medicaid Services (CMS) reviewed the proposed Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0005. This SPA removes prior authorization requirements for rehabilitative behavioral health services, as well as services provided by community behavioral health service (CBHS) clinics and mental health physician clinics. Additionally, it removes the requirement that CHBS clinics be a grantee of the Division of Behavioral Health, includes a technical correction to rehabilitative services, and revises the target group and provider qualifications for behavioral health targeted case management.

We conducted our review of your submittal according to statutory requirements in Section 1902 of Title XIX of the Social Security Act (The Act) and implementing regulations at 42 Code of Federal Regulations (CFR) 440.90, 440.130, 440.169, and 441.18. This letter is to inform you that Alaska's Medicaid SPA Transmittal Number 25-0005 was approved on October 14, 2025, with an effective date of July 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Alaska State Plan.

If you have any questions, please contact Maria Garza at 206-615-2542 or via email at Maria.Garza@cms.hhs.gov.

Sincerely,

Nicole McKnight
On Behalf of Courtney Miller, MCOG Director

Enclosures

cc: Emily Ricci, Deputy Commissioner, Department of Health
Christal Hays, Alaska State Plan Coordinator
Eva Venema, Alaska State Plan Coordinator

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 5 — 0 0 0 5

2. STATE

AK3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL
SECURITY ACT

XIX



XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION

Sections 1902(a); 42 CFR 440.130, 440.90, 441.18 440.169*

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 25 \$ 0b. FFY 26 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attached Sheet to Attachment 3.1-A, page ~~3, 3.1*~~, 4.4, 4c, 6, 7,
and 9;~~Supplement 1 to Attachment 3.1-A, pages 1, 1a, and 2 *~~

Attached Sheet to Attachment 3.1-A, pages 3 - 3.1d*

Supplement 1 to Attachment 3.1-A, pages 1-2b*

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)Attached Sheet to Attachment 3.1-A, page ~~3, 3.1, 4.4, 4c,~~ *~~Supplement 1 to Attachment 3.1-A, pages 1, 1a, and 2~~ *

Attached Sheet to Attachment 3.1-A, pages 3- 3.1e (template)*

Supplement 1 to Attachment 3.1-A, pages 1-2*

9. SUBJECT OF AMENDMENT

Removes service authorization and grantee requirements for Community Behavioral Health Services (CHBS) providers/mental health physician clinics and revises case management language for behavioral health services.

10. 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:

Regulations pending adoption, which are reviewed by Lt. Gov.

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME

Emily Ricci

13. TITLE

Deputy Commissioner & Medicaid Director

14. DATE SUBMITTED

June 2, 2025

15. RETURN TO

Dept of Health Commissioner's Office

c/o Christal Hays

3601 C Street, Suite 902

Anchorage, AK 99503

FOR CMS USE ONLY

16. DATE RECEIVED

June 2, 2025

17. DATE APPROVED

October 14, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

Nicole McKnight

21. TITLE OF APPROVING OFFICIAL

On Behalf of Courtney Miller, MCOG Director

22. REMARKS * reflects (P&I) authorized changes

9/17/25 AK authorizes the following changes: (1) BOX 7 ~~updating pagination of Attached Sheet to Attachment 3.1-A, 3-3.4 & adds (template) & BOX 8 to reflect last version of the pagination for template pages, Attached Sheet to Attachment 3-3.4 & (template) BOX 7 update to pagination for Supplement 1 to Attachment 3.1-A, pages 1-2b, & BOX 8 updated Supplement 1 to Attachment 3.1-A, to reflect pages 1-2~~

09/10/25 BOX 5 - added citation for TCM (440.169)

10/7/25 correction P&I changes to Clinic Svc Template - w/i Box 7 Attachment 3.1-A, pages 3 - 3.1d & Box 8 Attachment 3.1-A, pages 3 - 3.1e to reflect correct pagination.

State Plan under Title XIX of the Social Security Act
State/Territory: Alaska

Section 1905(a)(9) Clinic Services

The state provides coverage for this benefit as defined at section §1905(a)(9) of the Social Security Act (the Act) and 42 C.F.R. 440.90 and as described as follows:

General Assurances

[Select all three checkboxes below.]

- ☒ The state assures services are furnished by a facility that is not part of a hospital in accordance with 42 C.F.R. 440.90.
- ☒ The state assures that services are furnished by facilities that are organized and operated to provide medical care to outpatients in accordance with 42 C.F.R. 440.90.
- ☒ The state assures that services are furnished under the direction of a physician or dentist in accordance with 42 C.F.R. 440.90(a).

Types of Clinic Services and Limitations in Amount, Duration, or Scope

[Select if applicable, describe below, and indicate if limits may be exceeded based upon state determined medical necessity criteria.]

- ☐ Limitations apply to all services within the benefit category.
Click or tap here to enter text.

Types of Clinics and Services:

[Select all that apply and describe below as applicable]

- ☒ Behavioral Health Clinics **[Describe the types of behavioral health clinics below and select below if applicable.]:**
 - Community Behavioral Health Provider –
A. Definition of services - The Medicaid agency or designee will reimburse a community behavioral health services provider for the provision of approved services for the treatment of diagnosable behavioral health disorders, including mental health and substance use disorders, provided to eligible Medicaid beneficiaries.
 - Mental Health Physician Clinic–
A. Definition of services – The Medicaid agency or designee will reimburse a mental health physicians’ clinic for the provision of approved state plan services for the treatment of diagnosable mental health disorders provided to Medicaid eligible beneficiaries.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Alaska

Section 1905(a)(9) Clinic Services

☐ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**

☒ IHS and Tribal Clinics **[Select below if applicable.]:**

☐ Limitations apply only to this clinic type within the benefit category.

[describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria].

Click or tap here to enter text.

☒ Renal Dialysis Clinics **[Select below if applicable.]:**

End Stage Renal Disease Clinics

A. Definition of services: End stage renal disease services include comprehensive outpatient dialysis and related services including labs and drugs, home dialysis training and support services, or both.

B. Providers and qualifications: The end stage renal disease provider must comply with all current federal (42 CFR 494.1 – 494.20) and state enrollment requirements and be enrolled as a Medicare provider.

☒ Limitations apply only to this clinic type within the benefit category.

[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]

C. Prior authorization and limitations: The facility may bill a maximum of one peritoneal dialysis treatment per day, and a maximum of three hemodialysis treatments per week. Treatment limits may be exceeded based on medical necessity determination.

☒ Other Clinics **[Describe the types of clinics, if any limitations apply, and select below if applicable.]:**

Ambulatory Surgery Center

A. Definition of services: Ambulatory surgical center (ASC) means any distinct entity operating exclusively for providing surgical services to patients not requiring hospitalization, and in which the expected duration of services would not exceed 24 hours following an admission. (42 CFR 416.2).

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State Plan under Title XIX of the Social Security Act
State/Territory: Alaska

Section 1905(a)(9) Clinic Services

- ☒ Limitations apply only to this clinic type within the benefit category. **[Describe below and indicate if limits may be exceeded based upon state determined medical necessity criteria.]**
- B. Providers and qualifications: Ambulatory surgical centers must comply with all current federal (42 CFR 416.25 – 416.54) and state enrollment requirements, have a system to transfer patients requiring emergency admittance or overnight care to a licensed, Medicaid-enrolled facility following any surgical procedure performed, and have a department approved utilization review plan.
- C. Prior authorization and limitations: Services requiring prior authorization are noted on the current ASC fee schedule

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN NO: AK 25-0005

Supersedes TN: AK 25-0004

Approval Date: October 14, 2025

Effective Date: July 1, 2025

State Plan under Title XIX of the Social Security Act
State/Territory: Alaska

Section 1905(a)(9) Clinic Services

Four Walls Exceptions

The state assures that the following services may be furnished outside of the clinic **[Select the first and second checkbox; Do not select the second checkbox if the state does not enroll IHS or Tribal facilities as providers of clinic services.]**:

☒ Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address in accordance with 42 C.F.R. 440.90(b).

☒ Services furnished outside a clinic that is a facility of the Indian Health Service, whether operated by the Indian Health Service (IHS) or by a Tribe or Tribal organization (as authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638), by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(c).

The state elects to cover the following services outside of the clinic **[Select all that apply.]**:

☒ Services furnished outside of a clinic that is primarily organized for the care and treatment of outpatients with behavioral health disorders, including mental health and substance use disorders, by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(d) **[Describe the types of behavioral health clinics such exception applies to below.]**:

Community Behavioral Health Service and Mental Health Physician Clinics

☐ Services furnished outside of a clinic that is located in a rural area and is not a rural health clinic (as referenced in section §1905(a)(2)(B) of the Act and 42 C.F.R. 440.20(b) of this subpart) by clinic personnel under the direction of a physician in accordance with 42 C.F.R. 440.90(e) **[Select one of the checkboxes below and describe the definition of a rural area that applies to this exception.]**:

☐ A definition adopted and used by a federal governmental agency for programmatic purposes **[Describe below.]**:

[Click or tap here to enter text.](#)

☐ A definition adopted by a state governmental agency with a role in setting state rural health policy **[Describe below.]**:

[Click or tap here to enter text.](#)

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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State Plan under Title XIX of the Social Security Act
State/Territory: Alaska

Section 1905(a)(9) Clinic Services

Four Walls Exceptions (continued)

The state attests that **[Select the checkbox if the state elects to cover services outside of a clinic that is located in a rural area.]:**

- ☐ The selected definition of a rural area best captures the population of rural individuals that meets more of the four criteria that mirror the needs and barriers to access experienced by individuals who are unhoused:
- The population experiences high rates of behavioral health diagnoses or difficulty accessing behavioral health services;
 - The population experiences issues accessing services due to lack of transportation;
 - The population experiences a historical mistrust of the health care system; and
 - The population experiences high rates of poor health outcomes and mortality.

Additional Benefit Description (Optional)

At its option the state may provide additional descriptive information about the benefit, beyond what is included in the federal statutory and regulatory definitions and descriptions.

[Describe below.]:

Click or tap here to enter text.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(9) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #91). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Description of Service Limitations

12.c. Prosthetic Devices

Prosthetic devices are provided when prescribed by a physician or other licensed practitioner operating within their scope of practice.

12.d. Eyeglasses

Medicaid recipients twenty one (21) years of age and older may receive one complete pair of eyeglasses and a fitting per two calendar years without prior authorization. A recipient may obtain a two-year supply of contact lenses in lieu of glasses if determined medically necessary. A recipient may obtain an additional pair of glasses or an additional supply of contact lenses subject to a determination of medical necessity and prior authorization by the Medicaid agency or its designee.

The following vision products and services require prior authorization – based on medical necessity – from the Medicaid agency or its designee: ultraviolet coating, prism lenses, specialty lenses, specialty frames, and tinted lenses.

The department excludes the following vision products and services for Medicaid recipients twenty-one (21) years of age and older: aspherical lenses, progressive or no-line multi-focal lenses, vision therapy services, polarized lenses, and anti-reflective or mirror coating.

Eyeglasses are purchased for recipients under a competitively bid contract.

13. Diagnostic, Screening, Preventive, and Rehabilitative Services

13.a. Diagnostic services are provided in accordance with 42 CFR 440.130(a).

13.a.1. Mammography coverage is limited to diagnostic mammograms are necessary to detect breast cancer.

13.b. Screening mammograms are covered at the age and frequency schedule of the American Cancer Society.

13. c. Preventive Services

Coverage and provider qualifications are in accordance with 42 CFR 440.130. Alaska Medicaid covers all preventive services described in sections 1905(a)(13)(A) and (B) of the Social Security Act, including

- Evidence-based items or services with an A or B rating by the United State Preventive Services Task Force (USPSTF);
- Immunizations for use in children, adolescents, and adults that are recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, are covered without cost sharing. Changes to ACIP recommendations are incorporated into coverage and billing codes as necessary.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings are provided based on the current guidelines in the American Academy of Pediatrics Bright Futures periodicity schedule for screenings and follow-up visits;

(11) Advanced Practice Registered Nurse (A.P.R.N.) – an individual enrolled in Alaska Medicaid, holding an active license to practice in good standing in the State of Alaska, who may or may not hold state-granted independent prescriptive authority. When APRNs do not have independent prescriptive authority in the state, the APRN operates within the scope of their collaborative practice agreement for the purposes of prescribing and dispensing legend drugs;

(12) Licensed Practice Nurse (L.P.N.) – an individual working for an eligible and enrolled behavioral health rehabilitation services provider, holding an active license to practice in good standing in the State of Alaska, operating within their scope of practice under the supervision of a licensed registered nurse, licensed advanced practice registered nurse, licensed physician, licensed physician's assistant, or licensed dentists; and

(13) Certified Nursing Aide (C.N.A.) – an individual working for an eligible and enrolled behavioral health rehabilitation services provider, holding a State of Alaska certification and operating within their scope of practice under the supervision of a licensed nurse.

The state assures that any willing and qualified provider operating within the scope of their license or certification under state or federal law who delivers the services listed below to eligible recipients may receive Medicaid reimbursement regardless of the setting in which the service is furnished.

Pursuant to EPSDT, no limitations on services listed in this section are imposed for individuals under 21 years of age, if determined to be medically necessary and prior authorized by Alaska Medicaid.

13.d. Rehabilitative behavioral health disorder services - continued

- (1) **Screening Services** used to determine whether a Medicaid-eligible individual may need behavioral health intervention or treatment are covered by Medicaid. The types of screening eligible for reimbursement by the Medicaid agency or its designee include.

- a. **Behavioral Health Screening Services** include the use of evidence-based tool. This behavioral health screening is used with a recipient before an intake assessment for diagnosis and treatment is conducted.

Provider Qualifications: Behavioral health screenings may be conducted by a community behavioral health services provider and any other providers eligible to bill Medicaid for services and who perform screening services as a regular duty within the scope of their knowledge, experience, and education.

Service Limitations: Behavioral health screenings may be provided to a recipient without prior authorization by the Medicaid agency or its designee.

course of active treatment, as necessary. A mental health intake assessment must be documented in the recipient's clinical record in accordance with state law.

Additional Provider Qualifications: If the mental health intake assessment is performed by a community behavioral health services provider, the assessment must be conducted in accordance with the specific requirements for community behavioral health services providers in state law.

Service Limitations: A qualified provider may furnish a mental health intake assessment in combination with a substance use intake assessment for an individual not currently receiving services based on a behavioral health treatment plan if the assessment consists of face-to-face session(s) and a review of collateral information regarding the individual's condition.

- (ii) **Substance Use Intake Assessment:** This assessment is used to determine and document whether a Medicaid-eligible individual has a substance use disorder and functional impairment, the nature and severity of any identified substance use disorder, the correct diagnosis, treatment recommendations for the behavioral health treatment plan, and new information as it becomes available. These intake assessments are conducted upon admission to services and during active treatment as necessary and completed in accordance with state law. A substance use intake assessment must be documented in the recipient's clinical record in accordance with state law.

Additional Provider Qualifications: Substance use intake assessments must be rendered by a substance use disorder counselor, a behavioral health clinical associate, or other provider types in 13.d. of this section acting within the scope of their individual training, experience, and assigned job duties. A community behavioral health services provider may provide an assessment under this section if the service was rendered by an authorized provider and in accordance with state law.

Service limitations: A qualified provider may furnish a substance use intake assessment in combination with a mental health intake assessment for an individual not currently receiving services based on a behavioral health treatment plan if the assessment consists of face-to-face session(s) and a review of collateral information regarding the individual's condition. Substance use intake assessments may be provided to a recipient without prior authorization by the Medicaid agency or designees.

(iii) Integrated Mental Health and Substance Use Intake Assessment: This assessment is used to determine and document whether a Medicaid-eligible individual has a mental health and/or substance use disorder(s) and any related functional impairments. The integrated intake assessment must meet the requirements for both the mental health and substance use intake assessments established by Alaska Medicaid or its designee and be updated by the provider as new information becomes available. An integrated intake assessment must be documented in the recipient's clinical record in accordance with state law.

Additional Provider Qualifications: If the mental health intake assessment performed by a community behavioral health services provider, the assessment must be conducted in accordance with the specific requirements for community behavioral health services providers in state law.

Service Limitations: A qualified provider may furnish an integrated intake assessment for an individual not currently receiving services based on a behavioral health treatment plan if the assessment consists of face-to-face session(s) and a review of collateral information regarding the individual's condition. Integrated mental health and substance use intake assessments may be provided to a recipient without prior authorization by the Medicaid agency or designees.

(c). Behavioral Health Rehabilitative Services are allowable as an outpatient benefit within limitations described in this section. Behavioral health rehabilitative services are provided to Medicaid-eligible recipients to remediate and ameliorate debilitating effects of substance use and mental health disorders for the maximum reduction of each disabling condition. These services help the recipient develop appropriate skills to improve overall functioning with the goal of maximum restoration.

Service Limitations: The following services are available for children under 21 years of age with an appropriate diagnosis resulting from an EPSDT screen or assessment. Pursuant to EPSDT, no limitations on services are imposed for individuals under 21 years of age if determined to be medically necessary and prior authorized by Alaska Medicaid. Services may be provided to seriously mentally ill and severely emotionally disturbed adults.

- (i) **Therapy and Treatment** includes treatment, therapeutic interventions, and rehabilitative services designed to alleviate behavioral health disorders (mental, emotional and/or substance abuse related) and encourage growth and development while helping to prevent relapse of such conditions, including coaching and teaching life skills to restore functioning and support community

and directly monitoring the recipient's response to medication, including documenting medication compliance, assessing, and documenting side effects, and evaluating and documenting the effectiveness of the medication

Provider Qualifications: Authorized professionals for this service are limited to a licensed physician, licensed physician assistant, or licensed and certified advanced practice registered nurse, if the authorized provider is working within the scope of the provider's education, training, and experience, has prescriptive authority, and is enrolled with Alaska Medicaid as a dispensing provider. The authorized provider must directly provide pharmacological management services and monitor the effects thereafter.

Service Limitations: Pharmacologic management services may be provided to a recipient without prior authorization by the Medicaid agency or designees.

(v) Medication-Assisted Treatment is a type of pharmacological service prescribed by an authorized practitioner that, in combination with counseling and behavioral therapies, provides a "whole-patient" approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA), consistent with 42 U.S.C. 1396r-8(k)(2), clinically driven, and tailored to meet each patient's needs.

Provider Qualifications: physicians, physician assistants, and advanced practice registered nurses in a community behavioral health services provider who is performing the service in a substance use disorder treatment program as a regular duty within the scope of their knowledge, experience, and education, and any other licensed or certified providers operating within their scope of practice under state law.

TARGETED CASE MANAGEMENT SERVICES

Behavioral Health

A. Target Group

The target group consists of Medicaid eligible children and adults who are at risk or currently experiencing symptoms of mental illness or substance use disorder.

___Target group includes individuals transitioning to a community setting. Case- management services will be made available for up to ____ **[insert a number; not to exceed 180]** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

B. Areas of State in which services will be provided

- ☒ Services are provided throughout the 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:

C. 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. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B).

D. Definition of services

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

1. **Comprehensive assessment** and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:
 - a. Taking client history;
 - b. Identifying the needs of the individual, and completing related documentation; and
 - c. Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual;
 - i. Comprehensive assessments are completed at intake to create an individualized treatment plan.
 - ii. The directing clinician reviews and updates the plan at least every 90 days, as required by Alaska regulations, to ensure services remain appropriate and to address new needs.
 - iii. Reassessments may occur during these reviews or whenever the clinician identifies an unmet need in the care plan.
2. **Development (and periodic revision) of a specific care plan** based on the information collected through the assessment, that includes the following:
 - a. Specifies the goals and actions to address the medical, social,

- educational, and other services needed by the eligible individual;
- b. 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;
- c. Identifies a course of action to respond to the assessed needs of the eligible individual;

The individual's specific care plan for treatment must be reviewed in person or by means of a telehealth modality with the individual at least every 90 days to confirm that the identified problems and treatment services are current and relevant, and to identify any need for continuing assessment or treatment services to address new problems identified by the provider or the individual.

3. **Referral and related activities** (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
4. **Monitoring and follow-up activities**, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:
 - a. Services are being furnished in accordance with the individual's care plan.
 - b. Services in the care plan are adequate.
 - c. There are changes in the needs or status of the eligible individual.Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

A directing clinician monitors case management services on a schedule based on the acuity of the individual's needs and treatment services included in the specific care plan. Monitoring may be conducted in person or by means of a telehealth modality.

5. Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs (42 CFR 440.169(e))

E. Qualifications of providers

1. Qualifications of Provider Organizations:
Provider organizations must obtain Department of Health approval to operate as a Community Behavioral Health Services provider, which includes, but is not limited to:
 - a. Satisfying national accreditation standards from a recognized body;
 - b. Obtaining programmatic approval to offer behavioral health rehabilitation services;
 - c. Ensuring administrative capacity to ensure quality of services in accordance with state and federal requirements; and
 - d. Maintaining a clinical record in compliance with state and federal requirements.
2. Qualifications of Case Managers within Provider Organizations:
 - a. Case management services may only be offered through a qualified provider organization, by a behavioral health professional operating within their scope of practice, or by a paraprofessional under the supervision of a qualified individual.
 - b. To satisfy (1)(a) above in meeting accreditation requirements, provider organizations are responsible to ensure individual case managers are
 - i. Qualified by education, training, and experience to perform their roles
 - ii. Receiving initial and ongoing case management training
 - iii. Demonstrating competence in service delivery, documentation, and coordination of care.

F. Freedom of Choice (42 CFR 441.18(a)(1)):

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.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Access to Services (\$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: [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

H. Access to Services (42 CFR 441.18(A)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The state assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan

2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plans.

I. Payment (42 CFR 441.18(a)(4)):

The state assures 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.

J. Case Records (42 CFR 441.189(a)(4)):

The state assures providers maintain case records that document for all individuals receiving case management as follows:

1. The name of the individual;
2. The dates of the case management services;
3. The name of the provider agency (if relevant) and the person providing the case management service;
4. The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
5. Whether the individual has declined services in the care plan;
6. The need for, and occurrences of, coordination with other case managers;
7. A timeline for obtaining needed services; and
8. A timeline for reevaluation of the plan.

K. Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 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 §440.169 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)).