DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

SEP 1 2009

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

RE: Idaho State Plan Amendment Transmittal Number #08-016

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Idaho State Plan Amendment (SPA) Transmittal Number #08-016.

This letter approves Idaho's formal request to revise the reimbursement methodology to pay other health professionals to administer mental health rehabilitation services. This SPA is approved effective September 1, 2009.

If you have any questions concerning this SPA, please contact me or have your staff contact Tom Couch, CMS' Boise Outstation Office, at (208) 334-9482 or via email at Thomas.Couch@cms.hhs.gov .

Sincerely,

Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Leslie Clement, Administrator
Paul Leary, Deputy Administrator
Rachel Strutton, State Plan Coordinator
Sheila Pugatch, Reimbursement Specialist

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **08-016**

2. STATE **IDAHO**

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

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

4. PROPOSED EFFECTIVE DATE
~~**July 1, 2009**~~ Sept. 1, 2009

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
Total ($) Federal Funds
FFY 2009 (7-1-09 – 9-30-09) – $934,000 FFY 2010 –
~~**$3,464,000**~~ – 0 – (P+I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

~~Attachment 4.19-B. page 23~~
Attachment 4.19-B. page 23a, 23b, 23c (P+I)
Attachment 3.1-C BBB pages 26, 27, 34, EBB pages 30, 41 and CBB pages 14 and 15 (P+I)
Attachment 3.1-C CBB page 15a, HMCPp.16 (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, ~~page 23~~
Attachment 3.1-C BBB pages 26, 27, 34, CBB pages 30, 41 and CBB pages 14 and 15 (P+I)
and HMCPp.16 (P+I)

10. SUBJECT OF AMENDMENT:
We are requesting this amendment to our State Plan to define the reimbursement methodology to pay other health professionals authorized to administer mental health rehabilitation services.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
L M Clement

13. TYPED NAME:
Leslie M. Clement

14. TITLE:
Administrator

15. DATE SUBMITTED: 12-11-08

16. RETURN TO:

Leslie M. Clement, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0036

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: DEC 12 2008

18. DATE APPROVED: SEP - 1 2009

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

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

23. REMARKS:

Pen + ink changes authorized by the state on 6/3/09.
Pen + ink change authorized by the state on 7/2/09
Pen and ink change authorized by State 8/26/09
Pen and ink change authorized by State 8/27/09
Pen + ink change authorized by state on 8/31/09

FORM HCFA-179 (07-92)

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 Outpatient Mental Health Services

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

- Evaluation and diagnostics
- Psychotherapy
- Pharmacological management
- Partial care
- Nursing
- Collateral Contact
- Occupational therapy

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

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

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

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan. Mental Health Clinic services are limited to twenty-six (26) services per calendar year including:

Psychotherapy Services. Limited to twenty-four (24) visits per calendar year.

Evaluation and Diagnostic Services. Limited to twelve (12) hours per calendar year in any combination of evaluative or diagnostic services and treatment plan development.

Excluded Services. The following MH Clinic services are excluded from the Basic Benchmark Benefit Package covered under the State Plan.

- Partial care
- Psychosocial rehabilitation

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 441.15.

limitations of practice imposed by state law, and according to applicable Department rules.

Dentures. Dentures for the purpose of restoring oral form and function due to loss of permanent teeth that would result in significant occlusal dysfunction are covered for adults and children.

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

Elective medical and surgical dental services are excluded from payment unless prior approved by the Department or its authorized agent.

The following limitations apply to dentures under the Basic Plan:

- Dentures (partial or full) are limited to one set every 6 years
- Pre-existing dentures (partial or full) must be at least 6 year old to qualify for a replacement

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

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

3.Q.2 Other Dental Care

The Basic Benchmark Benefit Package includes **Other Dental Care** permitted under sections 1905(a)(5)(B) and 1905(a)(6) of the Social Security Act. These services include professional dental services that are provided by a licensed dentist or denturist as described in the contractor's Office Reference Manual. Specific services covered for children are stated in the contractor's Office Reference Manual.

The Department will provide dental services for children through the month of their twenty-first (21st) birthday including diagnostic, preventative, restorative treatment, endodontics, periodontics, fixed and removable prosthodontics, maxillofacial prosthetics, oral surgery, orthodontics and adjunctive general services.

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

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

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

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

3.K.2 Outpatient Mental Health Services

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

- Evaluation and diagnostics (includes intake assessments, comprehensive diagnostic assessments, functional assessments, psychological testing, neuropsychological testing, and occupational therapy assessments)
- Psychotherapy
- Pharmacological management
- Partial care
- Nursing
- Collateral Contact
- Occupational therapy

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

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

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

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

- Individual, family and group psychotherapy services are limited to a maximum of forty-five (45) hours in a calendar year.
- A combination of any evaluative or diagnostic services and treatment plan development is limited to twelve (12) hours in a calendar year.

- Legend prenatal vitamins for pregnant or lactating women;
- Legend folic acid;
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and
- Legend Vitamin D and analogues.

Prescriptions for non-legend products will be covered as follows:

- Insulin;
- Disposable insulin syringes and needles;
- Oral iron salts; and
- Permethrin.
- Nicotine cessation products, diet supplements and weight loss products are excluded unless provided as PHA benefits.

3.J FAMILY PLANNING SERVICES (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Family Planning Services** permitted under sections 1905(a)(4)(C) of the Social Security Act.

3.K MENTAL HEALTH SERVICES

3.K.1 Inpatient Psychiatric Services (Medicare Advantage Plan)

In addition to Psychiatric Services covered under Inpatient Hospital Services, the Medicare/Medicaid Coordinated Benchmark Benefit Package includes **inpatient psychiatric services for individuals in Institutions for Mental Diseases** permitted under section 1905(a)(14) of the Social Security Act.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

Once a participant exhausts the Medicare Part A 190 days lifetime limit for inpatient mental health care in a psychiatric hospital, the services will be covered by Medicaid.

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

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

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

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

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

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

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

- Evaluation and diagnostic services
- Individual, group and family psychotherapy services
- Community crisis support services

Individual and group skill training or community reintegration services

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

- Psychiatrist
- Physician or practitioner of the healing arts
- Psychologist or psychologist extender
- Social Worker (Masters, Clinical, Licensed)
- Clinical Professional Counselor
- Professional Counselor
- Marriage & Family Therapist (Associate Marriage & Family Therapist)
- Certified psychiatric nurse
- Professional Nurse (RN)
- Occupational Therapist
- PSR Specialist - must have a bachelor's degree in one (1) identified subject area as listed in Department rule. PSR Specialists are not licensed; they are required by Department rule to obtain PSR Specialist Certification, in accordance with USPRA requirements, by 2012. Reference IDAPA 16.03.10.131.03.

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

- A combination of any evaluation or diagnostic services is limited to a maximum of six (6) hours in a calendar year.
- Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours in a calendar year.
- Community crisis support services are limited to a maximum of seven (7) consecutive days and must receive prior authorization from the Department.

- Individual and group skill training or community reintegration services are limited ten (10) hours per week in any combination.

Excluded services. The following services are excluded PRS services:

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

3.L HOME HEALTH CARE (Medicare Advantage Plan)

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

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

3.M THERAPY SERVICES (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Therapy Services** permitted under sections 1905(a)(11), 1905(a)(13) of the Social Security Act. These services include physical therapy, occupational therapy, or speech pathology and Audiology services.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

3.N SPEECH, HEARING AND LANGUAGE SERVICES (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Speech, Hearing and Language Services** permitted under section 1905(a)(6) of the Social Security Act.
Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

The agency's rates are set from 07/01/1980 on and are effective for services on or after that date. All rates are published on the DME fee schedule at the agency's web site:

http://www.dme.idaho.gov

"Hearing Aids" are described in Idaho's Basic Benchmark Benefit Package in Section 3.N, and in Idaho's Enhanced Benchmark Benefit Plan in Section 3.N

d. Eye Glasses — Payments to providers for eye glasses are made at the lower of: the usual and customary charges; or the Department's medical assistance unit established fee schedule.

The agency's rates are set from 07/01/1980 on and are effective for services on or after that date. All rates are published on the DME fee schedule at the agency's web site:

http://www.dme.idaho.gov

"Eye Glasses" are described in Idaho's Basic Benchmark Benefit Package in Section 3.P., and in Idaho's Enhanced Benchmark Benefit Plan in Section 3.P.

13. d. Rehabilitation Services - The rate of reimbursement for each component of ambulatory services included in the State's Medicaid Plan will be established by the Department's medical assistance unit. This reimbursement rate will not exceed the usual and customary charges for comparable services under comparable circumstances in public and private agencies in the State of Idaho.
Rate(s):

For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule. The following CPT codes represent the service codes paid to rehabilitative physician mental health service providers:

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

http://www.healthandwelfare.idaho.gov

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

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

Code	Description	Rate of Reimbursement
90887	Collateral Contact (per 15 min.)	$11.35
H0031	Functional Assessment (per 15 min.)	$11.35
H2014	Group Skill Training (per 15 min.)	$2.77
H2017	Individual Skill Training (per 15 min.)	$11.35
H0036	Community Reintegration (per 15 min.)	$11.35
T1028	Intake Assessment (per 15 min.)	$9.94

The agency's rates are set from 09/01/2009 on and are effective for services on or after that date.

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

14. Services for individuals age 65 or older in institutions for mental diseases.
    b. & c. Skilled Nursing Facility Services — Refer to Attachment 4.19-D.
    a. & b. Intermediate Care Facilities for the Mentally Retarded - Refer to Attachment 4.19-D

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