DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

AUG 27 2009

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

RE: Idaho State Plan Amendment (SPA) Transmittal Number (TN) #09-011

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services' (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number #09-011. This amendment will bring the state into compliance with CMS-2237-F regarding Targeted Case Management for the adults with Mental Illness.

This SPA is approved effective July 1, 2009.

If you have any additional questions or require any further assistance, please contact me or have your staff contact Priya Helweg at (206) 615-2598 or Priya.Helweg@cms.hhs.gov.

Sincerely,

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **09-011**

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
7/1/2009

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:
1905(a)(19)

7. FEDERAL BUDGET IMPACT: (PoI)
~~Neutral~~
FFY 2009 - ($26,268) and FFY = 2010 ($105,073)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 3.1-C Enhanced Benchmark Plan – Pages 32, 32a, 32b, 32c, 32d, 33
Attachment 4.19-B – Pages 32, 32a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Section 3.1-C Enhanced Benchmark Plan – Pages 32, 33
Attachment 4.19-B – Page 32

10. SUBJECT OF AMENDMENT: To comply with CMS-2237-~~IFC~~ F (PoI) regarding Targeted Case Management.

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

12. SIGNATURE OF STATE ~~AGENCY~~ OFFICIAL:

13. TYPED NAME:
LESLIE M. CLEMENT

14. TITLE:
Administrator

15. DATE SUBMITTED: 5-28-09

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: MAY 29 2009

18. DATE APPROVED: AUG 27 2009

PLAN APPROVED – ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

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

23. REMARKS:
State authorized PoI change 8/17/09
State authorized PoI change 8/21/09

FORM HCFA-179 (07-92)

3.K.4 Case Management Services

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 with serious and persistent mental illness 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)

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

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]
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:

- Comprehensive 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:
Case management must only be provided by a service coordination agency enrolled as a Medicaid provider. Agencies must provide supervision to all case managers.

Agency Supervisor.
Education and Experience.

- Master's Degree in a human service field from a nationally accredited university or college and twelve (12) months experience in a mental health treatment setting with the serious and persistent mentally ill population; or
- Bachelor's degree in human services field from a nationally accredited university or college or licensed professional nurse (RN) degree and twenty-four (24) months experience in a mental health treatment setting with the serious and persistent mentally ill population.

Case Manager.
Education and Experience. Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and twelve (12) months experience working with the serious and persistent mentally ill population; or be a licensed professional nurse (RN) and twelve (12) months experience working with the serious and persistent mentally ill population. Individuals who meet the education or licensing requirements but do not have the required work experience, may work as a case manager under the supervision of a qualified case manager while they gain this experience.

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 with chronic mental illness. Providers are limited to 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 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 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))

Additional limitations:

- Reimbursement for on-going case management is not reimbursable prior to the completion of the assessment and service plan.

- Reimbursement is not allowed for missed appointments, attempted contacts, leaving messages, travel to provide the service, documenting services or transporting the participant.

3.L HOME HEALTH CARE

The Enhanced Benchmark Benefit Package includes **Home Health Care Services** permitted under sections 1905(a)(7), 1905(a)(8), 2110(a)(14) and 2110(a)(15) of the Social Security Act.

3.L.1 Home Health Services

The Enhanced Benchmark Benefit Package includes **Home Health Services** permitted under sections 1905(a)(7), 2110(a)(14) and 2110(a)(15) 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. The following service limitations apply to the Enhanced Benchmark Benefit Package covered under the State Plan.

19. Case Management Services

Rate(s):

For the Mentally Ill, Personal Care Services, Developmentally Disabled, and Children up to age 21 participants, 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
G9001	Plan Development	Personal Care
G9007	Plan Development	Developmentally Disabled
G9012	Plan Development	Children up to age 21
H0031	Plan Development	Mental Health
G9002	Targeted Service Coordination	Developmentally Disabled
G9002	Targeted Service Coordination	Children up to age 21
G9002	Targeted Service Coordination	Personal Care
T1017	Targeted Service Coordination	Mentally Ill
H2011	Community Crisis Support	Developmentally Disabled
H2011	Community Crisis Support	Children up to age 21
H2011	Community Crisis Support	Personal Care
H2011	Community Crisis Support	Mentally Ill

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 07/01/09 to be effective for services on or after 07/01/09.

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.

Claims Payment Process:

The MMIS will assure that each participant does not get billed for more than forty-eight (48) 15-minute units a year for plan development services for developmentally disabled, twenty-four (24) 15-minute units a year for plan development services for personal care services, for mentally ill, and for children up to age 21 participants. The MMIS will assure that each participant does not get billed for service coordination services for more than eighteen (18) 15-minute units a month for developmentally disabled, thirty-two (32) 15-minute units a month for personal care services, twenty (20) 15-minute units a month for mentally ill, and eighteen (18) 15-minute units a month for children up to age 21 participants.

Unit Billing Limitations:

Case management services unit billing is limited to the amount of time a case manager works in a day and cannot include time that is non-billable as established in Idaho Administrative Code Rule.

Post Review:

Idaho Medicaid will prior authorize units that exceed the established limit in cases where individuals receiving services meet medical necessity criteria established in Idaho Administrative Code Rule. If any such claim does not meet the criteria for medical necessity, Idaho Medicaid will recoup overpayments. The recoupment of payments will be processed as an adjustment to future or current period payment.

20. Special Services Related to Pregnancy – Payment for Risk Reduction Follow-up, Individual and Family Social Services, Nutrition Services, Nursing Services, Maternity Nursing Visits and Qualified Provider Risk Assessment and Plan of Care will be reimbursed at the lowest of:

A. The provider's actual charge for the service; or

B. The provider's median charge for a given service; or

C. The maximum allowable charge for the service as established by the Department's Medical Assistance Unit on its pricing file.

The fee schedule and any annual/periodic adjustments to the fee schedule for special services related to pregnancy are published at the following web site:

http://www.healthandwelfare.idaho.gov

The fee schedule was last updated on 07/01/1980 to be effective on or after that date.