Dear Senators LODGE, Broadsword & Werk, and
Representatives BLOCK, Nielsen & Henbest:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Dept. Of Health & Welfare: IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-0803) (Proposed) .

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 11-12-08. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 12-10-08.

_____The germane joint subcommittee may request a statement of economic impact with respect to a proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement, and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has been held.

To notify Research and Legislation, call 334-2475, or send a written request to the address or FAX number indicated on the memorandum enclosed.

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

FROM: Research & Legislation Staff - Paige Alan Parker

DATE: October 23, 2008

SUBJECT: Department of Health and Welfare - IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-0803) (Proposed)

This temporary and proposed rule docket 16-0310-0803 (hereinafter "proposed rule") represents the Department of Health and Welfare's amendments to chapter 16.03.10 dealing with Medicaid enhanced plan benefits.

The Department's purpose in revising the rule is to reform Medicaid's mental health program to help minimize duplication of services, eliminate overlapping components and contradictory requirements, better match benefits to participant needs, and better ensure that program resources are appropriately used and services are delivered by qualified providers.

According to the Department, the proposed rule is authorized pursuant to sections 56-202(b), 56-203(g), 56-203(i), and 56-250 through 56-257, Idaho Code.

Section 56-202(b), Idaho Code, provides the Department with general and broad rulemaking authority. Section 56-203(g), Idaho Code, grants the Department the power to define persons entitled to medical assistance in such terms as will meet requirements for federal participation in medical assistance payments. Section 56-203(I), Idaho Code, empowers the Department to determine the amount, duration and scope of care and services to be purchased as medical assistance on behalf of needy eligible individuals. Sections 56-250 through 56-255, Idaho Code, are the codified provisions of the Idaho Medicaid Simplification Act (HB 776 (2006)). Part of the legislative intent of that Act is to strive to balance efforts to contain Medicaid costs, improve program quality and improve access to services. Section 56-251(1), Idaho Code. Section 56-253(8), Idaho Code, gives the Department's director the authority to promulgate rules consistent with that Act. Sections 56-256 and 56-257, Idaho Code, deal with Personal Health Accounts and Co-payments, respectively, and are not relevant to the present proposed rule.

According to the Department, no fee or charge is imposed by the proposed rule. The Department states that proposed rule represents the beginning of a three year planning process to incorporate new evidenced-based benefits and best practices, including improving the management of existing benefits, incorporating standards and applying appropriate limits. Costs and cost containment will be identified as the rule is further defined, but the Department anticipates the overall impact will be to slow the expenditure growth of Medicaid-paid mental health services while improving quality and maintaining access. According to the Department, cost containment will be achieved by establishing clear assessment criteria and by reducing inappropriate utilization.

According to the Department, negotiated rulemaking with Medicaid providers was not conducted, but that stakeholder meetings were conducted with the Mental Health Providers Association, National Alliance for the Mentally Ill, Office of Consumer Affairs and Technical Assistance, Idaho Federation of Families, Idaho Psychological Association, National Association of Social Workers and various participants receiving mental health services and providers of mental health services.

Public hearings are scheduled in Coeur d'Alene on October 15, in Boise on October 17 and in Pocatello on October 10, 2008. All written comments must be directed and delivered to the Department's specified representative on or before October 22, 2008.

ANALYSIS

The proposed rule provides a new definition for "collateral contact," as the "coordination of care communication that is initiated by a medical or qualified professional with members of a participant's interdisciplinary team or consultant to the interdisciplinary team." New to the definition is what "collateral contact" is to be used for: "coordinate care between professionals who are serving the participant," "relay medical results and explanations to members of the participant's interdisciplinary team," or "conduct an intermittent treatment plan review with the participant and his interdisciplinary team." Section 010.21. This revised definition is also utilized in docket no. 16-0309-0803, dealing with Medicaid Basic Plan Benefits.

Under the proposed rule, added to the enhanced outpatient mental health services are community reintegration and skill training. Deleted from the list of these services is psychosocial rehabilitation. Section 110.

"Psychosocial rehabilitative services (PRS)" has been completely redefined by the proposed rule. Under the existing rule, these services were provided to SED children and SMI adults "to address functional deficits due to psychiatric illness and to restore independent living, socialization, and effective life management skills." The proposed rule is far more detailed and speaks in terms of "an array of rehabilitative services," including "skill development interventions and adaptations for daily living tasks that maintain or increase a participant's functional abilities." Other included services are "skill training [a newly defined term],

community reintegration [another newly defined term], and crisis intervention that provide programming that meets the participant's level of need in structure and intensity." These services are to "enable a participant to apply or maintain skills and thereby increase his ability to live independently in his community" and "are intended to target those behaviors and symptoms associated with the participant's mental illness that interrupt the participant's ability to accomplish desired tasks." Section 111.16.

Sixteen new definitions specific to enhanced outpatient mental health services are added by the proposed rule: "agency," "community reintegration," "comprehensive diagnostic assessment," "functional assessment," "intake assessment," "interdisciplinary team," "psychiatric nurse, licensed mater's level," "psychotherapy," "psychological testing," "recovery model," "restraints," "serious emotional disturbance (SED)," "serious mental illness (SMI)," "skill training," "treatment plan review," and "USPRA." Nine of these newly defined terms ("comprehensive diagnostic assessment," "functional assessment," "intake assessment," "interdisciplinary team," "psychotherapy," "restraints," "serious emotional disturbance (SED)," "serious mental illness (SMI)," and "treatment plan review") are also identically defined in proposed rule docket no. 16-0309-0803, Medicaid Basic Plan Benefits, at section 707, Mental Health Clinic Services.

Of these new definitions, only "serious emotional disturbance (SED)" is defined in statute at section 16-2403, Idaho Code, dealing with children's mental health services. The proposed rule's definition of "serious emotional disturbance" basically tracks the statute's definition, but modifies that definition by deleting the statement, "a disorder shall be considered to 'result in a serious disability' if it causes substantial impairment of functioning in family, school or community," and by adding "conduct disorder" and "development disorder" as conditions that, alone, do not constitute a serious emotional disturbance but that may co-exist with such a disturbance. Section 111.21. By including SED as a defined term within the definition section, the proposed rule is able to delete the similar definition for that term from section 112.02, dealing with eligibility criteria for children. Defining terms in rule that are contrary to established statutory definitions should be discouraged.

Of the remaining definitions, "interdisciplinary team," "psychotherapy," and "serious mental illness" are also defined in existing rules promulgated by the Department or by another agency. None of these terms are identically defined in the existing rules. However, these terms are defined consistently with proposed rule docket no. 16-0309-0803. Varying definitions between rule chapters is not inherently confusing if the definition is operational to the specific chapter, but an effort toward consistency should be maintained.

The definition of "interdisciplinary team" in the proposed rule ("[g]roup that consists of two (2) or more individuals in addition to the participant, the participant's legal guardian, and the participant's natural supports, including professionals from several fields who combine their skills and resources to provide guidance and assistance in the creation of the participant's treatment plan") is more detailed than the definition in IDAPA 16.03.13.010.11, dealing with

"Prior Authorization for Behavioral Health Services" ("the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration"). Section 111.10.

"Psychotherapy" is defined in IDAPA 24.14.01.010.03, "Rules of the State Board of Social Work Examiners," as "[t]reatment methods using a specialized, formal interaction between a Clinical Social Worker and an individual, couple, family, or group in which a therapeutic relationship is established, maintained, or sustained to understand unconscious processes, intrapersonal, interpersonal, and psychosocial dynamics, and the diagnosis and treatment of mental, emotional, and behavioral disorders, conditions, and addictions." In contrast, the proposed rule uses the abbreviated definition: "A method of treating and managing psychiatric disorders through the use of evidence-based psychotherapeutic modalities that focus on behavioral and cognitive aspects of a participant's abilities." Section 111.17.

The proposed rule states that its definition of "serious mental illness (SMI)" is in accordance with the Federal Register, Volume 58, page 29422 (June 24, 1999). The date of this citation is in error and should be May 20, 1993. The proposed rule does not specifically list the disorders that are included within its definition, stating, instead, that the person "[c]urrently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR . . . ." Federal Register at Vol. 58, p. 29425, states that "[t]hese disorders include any mental disorder (including those of biological etiology) listed in DSM-III-R or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-III-R 'V' codes, substance use disorders and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness." In contrast to IDAPA 16.07.33.010.16, "Adult Mental Health Services," specifically lists schizophrenia, paranoia and other psychotic disorders, bipolar disorders (mixed, manic and depressive), major depressive disorders (single episode or recurrent), schizoaffective disorders and obsessive-compulsive disorders. The proposed rule also lists the criteria required to qualify as a "serious mental illness":

> Must have a functional impairment which substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness.

Section 111.22. By including SMI as a defined term within the definition section, the proposed rule is able to delete the similar definition of that term from section 112.03, dealing with eligibility criteria for adults.

The other newly defined terms in the proposed rule are: "agency," "community

reintegration," "comprehensive diagnostic assessment," "functional assessment," "intake assessment," "psychiatric nurse, licensed master's level," "psychological testing," "recovery model," "restraints" "skill training," "treatment plan review," and "USPRA" [United States Psychiatric Rehabilitation Association]. Many of these terms are used in the Department's existing rules without definition. All appear to be context appropriate.

Of these newly defined terms, "comprehensive functional assessment" is frequently utilized in the proposed rule. A "comprehensive functional assessment" is "a thorough assessment of the participant's current condition and complete medical and psychiatric history" and must include: a current mental status exam; a description of the participant's readiness and motivation to engage in treatment, participate in the development of the treatment plan and adhere to the treatment plan; and the five axes diagnoses under DSM-IV-TR with recommendations for level of care, intensity and expected duration of treatment services. Section 111.04.

Also of interest, "restraints" includes not only "the use of physical, mechanical, or chemical interventions to modify participant behavior" but also "the use of seclusion to attempt to modify participant behavior." Section 111.20.

One enhanced outpatient mental health services definitions have been modified by the proposed rule: "assessment hours." Under the proposed rule "assessment hours" includes the time allotted for completion of intake services. 111.01[sic 111.02].

At section 112, the proposed rule substitutes the newly defined term "comprehensive diagnostic assessment" for the existing, undefined term "comprehensive assessment." The proposed rule also provides that the participant must obtain a functional assessment the describes the need for skills training or partial care in order to obtain psychosocial rehabilitative or partial care services.

The proposed rule clarifies the eligibility requirements for children, specifying skill training and community reintegration as the services for which eligibility must be established. A child's level and type of functional impairment must be described in the functional assessment, initially using the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) and with subsequent scores obtained at regular intervals to determine the child's change in functioning as a result of mental health treatment. Items endorsed on that scale must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. The proposed rule changes the "substantial impairment" requirement by deleting the requirement of a full eight scale score of 80 or higher to scoring in the moderate range on at least two [up from one in the existing rule] CAFAS/PECFAS subscales (self-harmful behavior, moods/emotions or thinking). Section 112.05.

The adult eligibility requirements have also been clarified, specifying skill training and

community reintegration as the services for which eligibility must be established. The psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively. The details of the adult's level and type of functional impairment must be described in the functional assessment. Section 112.06.

Eligibility for services after discharge from psychiatric hospitalization has been modified by the proposed rule. Children and adults who meet certain eligibility requirements are immediately eligible for "enhanced outpatient mental health services," rather than the broadly defined "psychosocial rehabilitative services (PRS)" for 120 days following discharge. The individualized treatment plan must be documented in the medical record within 10 days of discharge. Section 112.07.a. Under the proposed rule, the individualized treatment plan no longer needs to be based "solely" on hospital records and past history. Once the individual treatment plan has been completed and properly documented, treatment may be initiated without additional assessment, qualification or Department authorization, although an intake assessment or a comprehensive diagnostic assessment must be completed within 10 days of the initiation of treatment. Sections 112.07.a.i and ii. To continue the services listed on the post-hospital treatment plan beyond 120 days, the provider must establish participant eligibility, including that the services are appropriate for the participant's circumstances. Section 112.07.b.

The proposed rule provides a new section 113 on intake assessment for enhanced outpatient mental health services. Intake assessments, meeting the requirements specified in another, cited rule, may be performed by PSR agencies and Mental Health Clinics for participants who transfer from other agencies. When the PSR agency is performing a comprehensive diagnostic assessment, an intake assessment must not be performed as an initial evaluation service.

The proposed rule, at section 114, clarifies that a comprehensive diagnostic assessment must be completed to determine eligibility for enhanced outpatient mental health services. Curiously, the proposed rule no longer specifically permits a licensed master's level psychiatric nurse to complete the assessment. Many of the specific items that must be included in the assessment have been deleted by the proposed rule, although the requirement for a five axis diagnosis under DSM-IV-TR, documented in a face-to-face evaluation, has been added. Many of the specific topics that must be addressed in the assessment under the existing rule have been moved to new section 115, dealing with functional assessments for enhanced outpatient mental health services.

New section 115 requires specified staff to complete a functional assessment for participants seeking skill training and community reintegration services or partial care services. The staff performing the CAFAS/PECFAS must be the same staff completing the functional assessment. The functional assessment must evaluate the participant's use of critical skills within the categories of skill training, identified in the comprehensive diagnostic assessment, that are needed for adaptive functioning in the various environments in which the participant lives. The provider should assess those identified functional skill areas that prohibit the participant

from completing desired tasks in day-to-day functioning. The functional assessment should include recommendations for training in one or two of the list of "skill areas" (transformed in the movement from existing sections 113.02 through .09, from "information areas" that "must be assessed initially and at least annually thereafter," to new sections 115.01 through .08 where they are "skill areas,") in which the participant is interested in improving skills: health or medical issues, vocational and education status, financial status, social relationships and supports, family status, basic living skills, housing and community and legal status.

Section 116 of the proposed rule on written individualized treatment plans has been clarified to require that the individual staff person responsible for providing each enhanced service be specified and to provide that treatment planning is reimbursable if conducted by a designated professional. The goals of a written individualized treatment plan have been modified to include skill training, community reintegration and psychopharmacology and to remove PSR. Section 116.01. The plan content requirements have been modified to cross reference IDAPA 16.03.09, "Medicaid Basic Plan Benefits," section 709, as minimum requirements, and to remove the list of specified requirements in the existing rule. Although there is overlap between the cross referenced plan requirements and the deleted requirements, they are not identical. The proposed rule requires that at least one objective is required in the areas that are most likely to lead to the greatest level of stabilization. Section 116.02.

The proposed rule requires that intermittent treatment plan reviews occur as medically necessary but must not exceed 120 days between reviews. Plans must be completely rewritten for participants who continue treatment beyond twelve months. Section 116.03. Deleted by the proposed rule are individual treatment plan subsections on mandatory annual and physician review, establishment of the plan's date and authorized (twelve month) time period. Existing sections 116.04, 05, 06 and 08. The proposed rule clarifies that the participant's legal guardian is authorized to participate in the choice of providers. Section 116.04.

The proposed rule reduces the availability of partial care services from 36 to twelve hours a week per eligible participant. Section 118.02. The proposed rule clarifies that partial care services must be identified as a service need through the participant's comprehensive diagnostic assessment and the functional assessment and provide interventions for stabilizing behavior. Sections 118.02.a.ii and iii.

Fundamental to the proposed rule is the clarification that "psychosocial rehabilitation" is a classification of services, including pharmacological management, skill training, community reintegration, group skill training, crisis intervention, collateral contact, nursing service and psychotherapy, each with separate goals. Thus, the proposed rule removes the specific goal of psychosocial rehabilitative services (PRS) (to aid participants in work, school, family community or other issues related to their mental illness, to aid in obtaining developmentally appropriate skills for independent living, and to prevent movement to a more restrictive living situation) and

provides that all such services must be based on measurable and behavioral specific and

achievable objectives in accordance with the treatment plan. Section 123.

With regard to pharmacological management, the proposed rule requires that medication prescriptions be issued to the participant in person (rather than by a designated individual in "visual contact" with the participant). Section 123.01.

The proposed rule defines "skill training" as "the service of providing instruction for skill development to the participant in a custom-tailored approach with the goal of increasing the participant's ability to function in the various environments he or his legal guardian choose." Section 123.02. Problematically, "skill training" is defined earlier in the proposed rule as "a curriculum-based method of presenting skill building concepts that meets the needs identified on the person's assessment, focuses on new interventions to minimize functional barrier, and promotes increased independence in thinking and behavior." Section 111.23. Different definitions for the same term in the same rule create confusion. The proposed rule modifies the list of attributes previously used to describe PSR to "skill training," to include: assistance in gaining and utilizing skills; assistance in gaining and utilizing skills necessary for managing personal finances, living arrangements and daily home care duties; individual interventions in social skill training directly related to the participant's mental illness; assistance for gaining and utilizing communications skills; medication education; and assistance for gaining and utilizing skills needed by the participant to arrange for transportation. Each of these individual attributes listed in the proposed rule contains additional information. Sections 123.02.a through g.

Similarly, the proposed rule states that "community reintegration" is "the service of providing practical information and support to a participant to help the participant maintain skills or to practice newly-acquired skills." Section 123.03. Earlier, the proposed rule defined "community reintegration" as "a psychosocial rehabilitation (PSR) service that provides practical information and support directed toward the participant maintaining his current functioning level or practicing newly-acquired life skills. This service is intended to help the participant integrate progress on his treatment plan objectives into daily life." Section 111.03. Again, multiple definitions for the same term in the same rule create confusion. The proposed rule provides that community reintegration includes: assisting the participant with self-administration of medications by verbal prompts; assisting the participant with maintaining or obtaining services that the participant usually takes care of for himself but is temporarily unable to do so because of an exacerbation of his symptoms; and working with the participant's legal guardian immediately following the delivery of a mental health service. Additional details are included in the proposed rule. Sections 123.03.a through c.

Under the proposed rule, "group psychosocial rehabilitation"has been changed to "group skill training." In the proposed rule this service includes educating participants on skills for adhering to the medical regimen and community living skills groups that focus on occupation-related symptom management and skills related to appropriate job or school-related behaviors. Section 123.04.

Collateral contact, under the proposed rule, is a reimbursable service when included in the participant's individualized treatment plan and is necessary to gather and exchange information with members of the participant's interdisciplinary team. The proposed rule clarifies that collateral contact is provided by the agency staff providing treatment services. Section 123.06.

The proposed rule removes the requirement that psychotherapy must be prior authorized. Section 123.08. The proposed rule also deletes occupational therapy from the list of services under PSR. Existing section 123.08.

Limitations on psychosocial rehabilitative services have been modified by the proposed rule. Assessments must not exceed: one hour per provider per participant for intake assessments; four hour per participant annually for comprehensive diagnostic assessments and one hour per provider per participant for functional assessments. Under the existing rule, the maximum was six hours annually for any combination of evaluation or diagnostic services. Section 124.01. Skill training is limited at two hours per week, with up to five additional weekly hours with prior authorization. Section 124.05. Community reintegration services are limited to three hours a week, with up to ten additional hours with prior authorization. Section 124.06. PSA agency services may be provided at a provider's office or clinic if the location is medically necessary to maximize the impact of the service. Section 124.07.a.

Under the proposed rule, PSR services that are excluded and not reimbursable under Medicaid include any basic service for the provision of housing, education, social services or transportation. The PSA agency staff is directed to refer participants to other types of service agencies for these services. Section 125.06.

Reimbursement of specific services that require prior authorization is authorized from the date the required documentation is received by the Department. The proposed rule provides that the specific documentation required for prior authorization is dependent on the request of additional services, deleting the listing of required documentation. Section 128.02. The proposed rule limits prior authorization to a six-month period, down from twelve months under the existing rule. Section 128.02.a. The Department, under the proposed rule, has 15 days to review a provider request to increase the hours or to change the type of service provided. Under the existing rule the Department had ten days to conduct its review. Section 128.04.

The proposed rule requires the provider to conduct the comprehensive diagnostic assessment and develop an individualized treatment plan for each participant with input from the interdisciplinary team. Section 129.04. When a provider believes that an individualized treatment plan needs to be revised, the revisions are to be made in collaboration with the interdisciplinary team and be justified and documented in the medical record. The provider is no longer required to include the recommendation and rationale for a revision in the 120 day review documentation. Section 129.06.

New is the staff-to-participant ratio for group services. Under the proposed rule, no group work is allowed for children under the age of six years; and ratio may not exceed 1:6 and the group must not exceed twelve participants for children ages six to twelve years; and the ratio may not exceed 1:10 and the group must not exceed twelve participants for children over twelve years of age. Section 130.07.

New is a family participation requirement. For children under six years, the participant's legal guardian must be present during the delivery of mental health services; for children ages six through twelve, the guardian must be actively involved; for children over twelve years, the legal guardian may participate. There is no requirement that the legal guardian participate in treatment sessions no matter what the age of the child. However, if the child is over twelve years of age, the reasons for excluding the legal guardian must be documented in the medical record. Section 130.08.

Also new are the limitations on restraints and seclusion. Restraints and seclusion must only be used when the participant's behavior poses a threat to physical harm to himself or others. Note that the definition of "restraints," section 111.20, includes "seclusion." Use of restraints and seclusions must be incorporated into the participant's individualized treatment plan; the agency must develop and implement specified written policies and procedures; the agency must complete an incident report for each use of restraints, including specified information; a behavior modification plan must be developed and approved following the use of restraints; restraints cannot be used for punishment, staff convenience or inability to manage the participant's behavior; and adverse techniques or interventions are not allowed under any circumstance. Section 130.11.

The proposed rule clarifies that the PSR agency is required to meet specified building, credentialing and ethic standards when the participants are in the agency building for any reason and any amount of time. Section 130.12.

The list of agency staff authorized to deliver direct services has been augmented by the proposed rule to include a licensed associate marriage and family therapist, section 131.05, but has been shortened to remove a licensed occupational therapist, existing section 131.11. The qualifications of a psychosocial rehabilitation specialist to deliver direct services has been modified to require that as of July 1, 2009, applicants to become such specialist for the delivery of Medicaid-reimbursable mental health services must either have the training, education and experience to sit for the USPRA PSR specialist certification examination or a bachelor's degree from a nationally accredited university in primary education, special education, adult education, counseling, human services, early childhood development, school psychology or a masters degree in psychology. Those individuals already working as PSR specialists may continue to do so until January 1, 2012, at which time they must meet the above requirements. Section 131.11.

Each individualized treatment plan goal and objective must be reviewed intermittently, but not more than 120 days apart under the proposed rule. Section 136.05. Failure to send a

requested copy of the review to the Department after the intermittent staffing review date may result in penalties. Section 136.05.a. The proposed rule clarifies that the 120 day review for children must include a new CAFAS/PECFAS for the purpose of measuring changes in the participant's functional impairment. Section 136.05.b. The proposed rule also clarifies that reimbursement is not allowed for scheduling appointments for any reason. The proposed rule deletes the limitation on reimbursement for more than one contact during a single 15 minute period, requiring, instead, that providers must comply with Medicaid billing requirements. Section 136.09.

The proposed rule deletes a provision permitting reimbursement for evaluations performed by qualified licensed occupational therapists. Existing section 140.08. The proposed rule specifically limits the services that may be provided during the last 30 days of inpatient stay to community reintegration services. Section 140.08.

SUMMARY

A number of technical issues are noted in the above analysis. However, the Department's proposed rule appears to be authorized under sections 56-202(b), 56-203(b) and 56-253(8), Idaho Code.

cc: Department of Health and Welfare
Tamara Prisock & Pat Guidry

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0803

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

FRIDAY OCTOBER 10, 2008 1:00 pm MDT	WEDNESDAY OCTOBER 15, 2008 1:00 pm PDT	FRIDAY OCTOBER 17, 2008 9:00 am MDT
H & W Region VI Office Room 210 421 Memorial Dr. Pocatello, ID	H & W Region I Office Large Conference Room 1120 Ironwood Drive Coeur d'Alene, ID	Medicaid Central Office Conference Room D&E 3232 Elder Street Boise, ID

The hearing sites will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Rules changes are being made to reform Medicaid's mental health program to: (1) help minimize duplication of mental health services, (2) eliminate overlapping components and contradictory requirements, (3) better match mental health benefits to participant's needs, and (4) better ensure that mental health program resources are appropriately used and services are delivered by qualified providers.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: NA

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

These rule changes reflect year one of a three-year planning process to incorporate new evidenced-based benefits and best practices. Also included are changes which improve the management of existing benefits, incorporating standards and applying appropriate limits. As rules are further defined, costs and cost-containment details will be identified. The overall impact is anticipated to slow the expenditure growth of Medicaid-paid mental health services while improving quality and maintaining access. Cost containment will be achieved by establishing clear assessment criteria and reducing inappropriate utilization.

NEGOTIATED RULEMAKING: Pursuant to 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. However, stakeholder meetings were conducted that included the Mental Health Providers Association, National Alliance for the Mentally Ill, Office of Consumer Affairs and Technical Assistance, Idaho Federation of Families, Idaho Psychological Association, National Association of Social Workers, and various participants receiving mental health services and providers of mental health services.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Pat Guidry at (208) 364-1813.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, October 22, 2008.

DATED this 5th day of August, 2008.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5564 phone (208) 334-6558 fax
dhwrules@dhw.idaho.gov

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-0803

010. DEFINITIONS A THROUGH D.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (3-19-07)

02. Active Treatment. Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a qualified mental retardation professional (QMRP) directed toward: the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or the prevention or deceleration of regression or loss of current functional status. (3-19-07)

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-19-07)

04. Allowable Cost. Costs that are reimbursable, and sufficiently documented to meet the requirements of audit. (3-19-07)

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-19-07)

06. Appraisal. The method of determining the value of property as determined by an American Institute of Real Estate Appraiser (MAI) appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (3-19-07)

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

08. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the

person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (7-1-07)T

09. **Audit**. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. (3-19-07)

10. **Auditor**. The individual or entity designated by the Department to conduct the audit of a provider's records. (3-19-07)

11. **Audit Reports**. (3-19-07)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-19-07)

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-19-07)

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (3-19-07)

12. **Bad Debts**. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (3-19-07)

13. **Bed-Weighted Median**. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (3-19-07)

14. **Capitalize**. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (3-19-07)

15. **Case Mix Adjustment Factor**. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. (3-19-07)

16. **Case Mix Index (CMI)**. A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. (3-19-07)

a. Nursing Facility Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. (3-19-07)

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (3-19-07)

c. State-Wide Average Case Mix Index. The simple average of all nursing facilities "facility wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. (3-19-07)

17. **Certified Family Home**. A home certified by the Department to provide care to one (1) or two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence. (3-19-07)

l8. **Chain Organization**. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (3-19-07)

19. **Claim**. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-19-07)

20. **Clinical Nurse Specialist**. A licensed professional nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

21. **Collateral Contact**. ~~*Contact made with a parent, guardian, or other individual having a primary relationship to the patient by an appropriately qualified treatment professional. The contact must be ordered by a physician, contained in the treatment plan, directed at the medical treatment of the patient, and documented in the progress notes or continuous service record.*~~ Coordination of care communication that is initiated by a medical or qualified professional with members of a participant's interdisciplinary team or consultant to the interdisciplinary team. This service must appear on the treatment plan and must be documented in the progress notes of the participant's medical record. Collateral contact is used to: ~~*(3-19-07)*~~( )

a. Coordinate care between professionals who are serving the participant; ( )

b. Relay medical results and explanations to members of the participant's interdisciplinary team; or ( )

c. Conduct an intermittent treatment plan review with the participant and his interdisciplinary team. ( )

22. **Common Ownership**. An individual, individuals, or other entities who have equity or ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (3-19-07)

23. **Compensation**. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (3-19-07)

24. **Control**. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (3-19-07)

25. **Cost Center**. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. (3-19-07)

26. **Cost Component**. The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually at July 1st of each year. (3-19-07)

27. **Cost Reimbursement System**. A method of fiscal administration of Title XIX and Title XXI which compensates the provider on the basis of expenses incurred. (3-19-07)

28. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-19-07)

29. **Cost Statements**. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (3-19-07)

30. **Costs Related to Patient Care**. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's

activity. They include, but are not limited to, costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (3-19-07)

31. Costs Not Related to Patient Care. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are nonallowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (3-19-07)

32. Customary Charges. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. (3-19-07)

33. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the Intermediate Care Facility for the Mentally Retarded (ICF/MR). However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (3-19-07)

34. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-19-07)

35. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (3-19-07)

36. Developmental Disability (DD). A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before the age of twenty-two (22) years of age; and (3-19-07)

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, which requires similar treatment or services or is attributable to dyslexia resulting from such impairments; (3-19-07)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (3-19-07)

37. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (3-19-07)

a. Direct nursing salaries that include the salaries of professional nurses (RN), licensed professional nurses, certified nurse's aides, and unit clerks; (3-19-07)

b. Routine nursing supplies; (3-19-07)

c. Nursing administration; (3-19-07)

d. Direct portion of Medicaid related ancillary services; (3-19-07)

e. Social services; (3-19-07)

f. Raw food; (3-19-07)

g. Employee benefits associated with the direct salaries: and (3-19-07)

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (3-19-07)

38. Director. The Director of the Department of Health and Welfare or his designee. (3-19-07)

39. Durable Medical Equipment (DME). Equipment other than prosthetics or orthotics which can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a medical assistance participant. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

110. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES.
In addition to mental health services covered under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 710 through 717, the Medicaid Enhanced Plan Benefits include~~s~~ the following enhanced outpatient mental health benefits. ~~*(3-19-07)*~~( )

01. ~~***Psychotherapy.*** *The enhanced services include additional psychotherapy in a Mental Health Clinic as described in Subsection 115.01 of these rules.*~~ **Community Reintegration**. The enhanced services include community reintegration as described in Sections 111 through 146 of these rules. ~~*(3-19-07)*~~( )

02. Partial Care Services. The enhanced services include partial care services in a Mental Health Clinic as described in Subsection 11~~5~~6.0~~2~~1 of these rules. ~~*(3-19-07)*~~( )

03. Psychotherapy. The enhanced services include additional psychotherapy in a Mental Health Clinic as described in Subsection 116.01 of these rules. ( )

03. ~~***Psychosocial Rehabilitation***~~ **Skill Training**. The enhanced services include ~~*psychosocial rehabilitation*~~ skill training as described in Sections 1~~23~~11 through 146 of these rules. ~~*(3-19-07)*~~( )

111. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - DEFINITIONS.
These definitions apply to Sections 100 through 146 of these rules. (3-19-07)

01. Agency. A Medicaid provider who delivers either mental health clinic services or psychosocial rehabilitative services, or both. ( )

01. Assessment Hours. Time allotted for completion of intake, evaluation and diagnostic services. ~~*(3-19-07)*~~( )

03. Community Reintegration. A psychosocial rehabilitation (PSR) service that provides practical information and support directed toward the participant maintaining his current functioning level or practicing newly-acquired life skills. This service is intended to help the participant integrate progress on his treatment plan objectives into daily life. ( )

04. Comprehensive Diagnostic Assessment. A thorough assessment of the participant's current condition and complete medical and psychiatric history. The comprehensive diagnostic assessment must incorporate information typically gathered in an intake assessment process if an intake assessment has not been completed by the provider agency conducting the comprehensive diagnostic assessment. The comprehensive diagnostic assessment must include: ( )

a. A current mental status examination; ( )

b. A description of the participant's readiness and motivation to engage in treatment, participate in the development of his treatment plan and adhere to his treatment plan; and ( )

c. The five (5) axes diagnoses under DSM-IV-TR with recommendations for level of care, intensity, and expected duration of treatment services. ( )

02~~.~~5. Demographic Information. Information that identifies participants and is entered into the Department's database collection system. (3-19-07)

06. Functional Assessment. In rehabilitative mental health, this assessment is used to provide supplemental information to the comprehensive diagnostic assessment that provides information on the current or required capabilities needed by a participant to maintain himself in his chosen environment. It is a description and evaluation of the participant's practical ability to complete tasks that support activities of daily living, family life, life in the community, and promote independence. This assessment assists participants to better understand what skills they need to achieve their rehabilitation goals. ( )

03. Goal. The desired outcome related to an identified issue. (3-19-07)

04. Initial Contact. The date a participant, or participant's parent~~,~~ or legal guardian comes in to an agency and requests Enhanced Plan services. ~~(3-19-07)~~( )

09. Intake Assessment. An initial assessment of the participant that is conducted by an agency staff person who has been trained to perform mental status examinations and solicit sensitive health information for the purpose of identifying service needs prior to developing an individualized treatment plan. The intake assessment must contain a description of the reason(s) the participant is seeking services and a description of the participant's current symptoms, present life circumstances across all environments, recent events, resources, and barriers to mental health treatment. If this is the initial screening process then it must be used to determine whether mental health services are a medical necessity for the participant. ( )

10. Interdisciplinary Team. Group that consists of two (2) or more individuals in addition to the participant, the participant's legal guardian, and the participant's natural supports, including professionals from several fields or professions who combine their skills and resources to provide guidance and assistance in the creation of the participants treatment plan. ( )

***05*11. Issue**. A statement specifically describing the participant's behavior directly relating to the participant's mental illness and functional impairment. (3-19-07)

***06*12. Licensed Practitioner of the Healing Arts**. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. The nurse practitioner and clinical nurse specialist must have experience prescribing psychotropic medication. (3-19-07)

***07*13. Objective**. A milestone toward meeting the goal that is concrete, measurable, time-limited, and behaviorally specific. (3-19-07)

***08*14. Partial Care**. Partial care is treatment for those children with serious emotional disturbance and adults with severe and persistent mental illness whose functioning is sufficiently disrupted so as to interfere with their productive involvement in daily living. Partial care services are a structured program of therapeutic interventions that assist program participants in the stabilization of their behavior and conduct through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition. (3-19-07)

15. Psychiatric Nurse, Licensed Master's Level. A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. ( )

~~*09*~~**16.** **Psychosocial Rehabilitative Services (PSR)**. ~~*Rehabilitative services provided both to children with serious emotional disturbance and to adults with severe and persistent mental illness to address functional deficits due to psychiatric illness and to restore independent living, socialization, and effective life management skills.*~~ An array of rehabilitative services that emphasize the Recovery Model for children with serious emotional disturbance and for adults with severe and persistent mental illness. These services include skill development interventions and adaptations for daily living tasks that maintain or increase a participant's functional abilities. These services also enable a participant to apply or maintain skills and thereby increase his ability to live independently in his community. PSR services are intended to target those behaviors and symptoms associated with the participant's mental illness that interrupt the participant's ability to accomplish desired tasks. PSR services include skill training, community reintegration, and crisis intervention that provide programming that meet the participant's level of need in structure and intensity. ~~*(3-19-07)*~~( )

17. **Psychotherapy**. A method of treating and managing psychiatric disorders through the use of evidenced-based psychotherapeutic modalities that focus on behavioral and cognitive aspects of a participant's abilities. ( )

18. **Psychological Testing**. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of an examinee's behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses or functional impairments. ( )

19. **Recovery Model**. An evidence-based treatment model that supports healing and transformation, enabling a participant with a mental health problem to live a meaningful life in a community of his choice while striving to achieve his full potential. It includes services for participants to build their skills to promote and manage their overall wellness. ( )

20. **Restraints**. Restraints include the use of physical, mechanical, or chemical interventions to modify participant behavior. It also includes the use of seclusion to attempt to modify participant behavior. ( )

21. **Serious Emotional Disturbance (SED)**. In accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, SED is: ( )

a. An emotional or behavioral disorder, according to the DSM-IV-TR which results in a serious disability; and ( )

b. Requires sustained treatment interventions; and ( )

c. Causes the child's functioning to be impaired in thought, perception, affect, or behavior. ( )

d. A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance. ( )

22. **Serious Mental Illness (SMI)**. In accordance with Volume 58 of the Federal Register, 29422-02, June 24, 1999, a person with SMI: ( )

a. Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR; and ( )

b. Must have a functional impairment which substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. ( )

23. **Skill Training**. A curriculum-based method of presenting skill building concepts that meets the needs identified on the person's assessment, focuses on new interventions to minimize functional barriers, and promotes increased independence in thinking and behavior. ( )

***10*24.** **Tasks**. Specific, time-limited activities and interventions designed to accomplish the objectives in the individualized treatment plan. (3-19-07)

25. **Treatment Plan Review**. The practice of holding a meeting among members of a participant's interdisciplinary team that is focused on evaluating the programs, progress, and future plans of a participant while providing feedback and suggestions intended to help team members and the participant to accomplish the participant's goals as identified on the participant's treatment plan. ( )

26. **USPRA**. The United States Psychiatric Rehabilitation Association is an association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. USPRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. http://www.uspra.org ( )

112. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - PARTICIPANT ELIGIBILITY.
To qualify for enhanced outpatient mental health services, a participant must obtain a comprehensive diagnostic assessment as described in Section 113 of these rules. The comprehensive diagnostic assessment for ***PSR, Partial Care, and Psychotherapy*** enhanced outpatient mental health services must include documentation of the medical necessity for each service to be provided. For partial care services, the comprehensive diagnostic assessment must also contain documentation that shows the participant is currently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration that would interfere with the participant's ability to maintain his current level of functioning. For PSR or partial care services, the participant must also obtain a functional assessment that describes the need for skills training or partial care, depending on which service is being sought. *(4-2-08)*( )

01. **General Participant Eligibility Criteria**. In order for a participant to be eligible for enhanced outpatient mental health services, the following criteria must be met and documented in the comprehensive diagnostic assessment: *(3-19-07)*( )

a. Other services have failed or are not appropriate for the clinical needs of the participant. (3-19-07)

b. The services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced. (4-2-08)

c. Participants identified in Subsections 112.01.c.i. through 112.01.c.iii. of this rule cannot participate in enhanced outpatient mental health services: (4-2-08)

i. Participants at immediate risk of self-harm or harm to others who cannot be stabilized; (4-2-08)

ii. Participants needing more restrictive care or inpatient care; and (4-2-08)

iii. Participants who have not fulfilled the requirements of Subsections 112.02 or 112.03 of these rules. (4-2-08)

02. **Eligibility Criteria for Children**. To be eligible for services, a participant under the age of eighteen (18) must have a serious emotional disturbance (SED). ***The following definition of the SED target population is based on the definition of SED found in the Children's Mental Health Services Act, Section 16-2403, Idaho Code.*** *(4-2-08)*( )

a. ***Presence of an emotional or behavioral disorder, according to the DSM-IV-TR which results in a serious disability; and*** *(4-2-08)*

b. ***Requires sustained treatment interventions; and*** *(3-19-07)*

~~***c.*** *Causes the child's functioning to be impaired in thought, perception, affect, or behavior.* *(3-19-07)*~~

~~***d.*** *A substance abuse disorder, or conduct disorder, or developmental disorder, alone, does not constitute a serious emotional disturbance, although one (1) or more of these conditions may co-exist with serious emotional disturbance.* *(3-19-07)*~~

03. Eligibility Criteria for Adults. To be eligible for services, a participant must be eighteen (18) years or older and have a serious mental illness (SMI) ~~*as defined in Volume 58 of the Federal Register, 29422-02, June 24, 1999*~~. ~~*(4-2-08)*~~( )

~~***a.*** *Currently or at any time during the year, he must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-IV-TR; and* *(4-2-08)*~~

~~***b.*** *He must have a functional impairment which substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness.* *(4-2-08)*~~

04. Level of Care Criteria - Mental Health Clinics. To be eligible for mental health clinic services, a participant must meet the criteria as described in Subsections 112.04.a. and 112.04.b. of this rule. (4-2-08)

a. Children must meet Subsections 112.01 and 112.02 of this rule. (4-2-08)

b. Adults must meet Subsections 112.01 and 112.03 of this rule. (4-2-08)

05. Level of Care Criteria - Psychosocial Rehabilitation (PSR) ~~*Agencies*~~ Services and Partial Care Services for Children. To be eligible for ~~*the*~~ partial care services ~~*of*~~ or the PSR ~~*or Partial Care*~~ services of skill training and community reintegration, a child must meet the criteria of SED and Subsections 112.0~~4~~1.~~*a.*~~ and 112.02 of this rule and must experience a substantial impairment in functioning. A child's level and type of ~~*F*~~functional impairment must be ~~*assessed using*~~ described in the functional assessment. ~~*t*~~The Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at regular intervals in order to determine the child's change in functioning that occurs as a result of mental health treatment. Items endorsed on the CAFAS/PEFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires ~~*a full eight (8) scale score of eighty (80) or higher with moderate impairment in at least one (1) of the following three (3) scales in Subsections 112.05.a. through 112.05.c. of this rule*~~ that the child score in the moderate range in at least two subscales on the CAFAS/PECFAS. One of the two (2) subscales must be from the following list. ~~*(4-2-08)*~~( )

a. Self-harmful behavior; (4-2-08)

b. Moods/Emotions; or (4-2-08)

c. Thinking. (4-2-08)

06. Level of Care Criteria - Psychosocial Rehabilitation (PSR) ~~*Agencies*~~ Services and Partial Care Services for Adults. To be eligible for partial care services ~~*of*~~ or the PSR ~~*or Partial Care*~~ services of skill training and community reintegration, an adult must meet the criteria of SMI and Subsections 112.0~~4~~1.~~*b.*~~ and 112.03 of this rule. In addition, the following criteria in Subsections 112.06.a. and 112.06.b. of this rule must be met. ~~*(4-2-08)*~~( )

a. The participant must have a diagnosis under DSM-IV-TR, of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis; and (4-2-08)

b. The psychiatric disorder must be of sufficient severity to ~~*cause*~~ affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the ~~*following*~~ areas in Subsection 112.0~~5~~6.b.i. through 112.0~~5~~6.b.viii. of this rule on either a continuous or an intermittent, at least once per year, basis. The detail of the adult's level and type of functional impairment must be described in the functional assessment: ~~*(4-2-08)*~~( )

i. Vocational/educational; (4-2-08)

ii. Financial; (4-2-08)

iii. Social relationships/support; (4-2-08)

iv. Family; (4-2-08)

v. Basic living skills; (4-2-08)

vi. Housing; (4-2-08)

vii. Community/legal; or (4-2-08)

viii. Health/medical. (4-2-08)

07. Criteria Following Discharge For Psychiatric Hospitalization. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules are eligible for enhanced outpatient mental health clinic and PSR services. (3-19-07)

a. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsection 112.02 of this rule for children, and in Subsection 112.03 of this rule for adults, are considered immediately eligible for ~~*PSR*~~ enhanced outpatient mental health services for a period of at least one hundred and twenty (120) days following discharge from the hospital. The individualized treatment plan must be completed and ~~*submitted to the Department for prior authorization*~~ documented in the medical record within ten (10) days of discharge. ~~*(4-2-08)*~~( )

i. Up to two (2) hours of plan development hours may be for coordinating with hospital staff and others the participant chooses. These plan development hours are to be used for the development of an individualized treatment plan based ~~*solely*~~ on the participant's hospital records and past history. The provider agency does not have to perform any additional assessment in order to initiate treatment nor does the participant need to qualify as described in Subsection 113.01 of these rules. ~~*(3-19-07)*~~( )

ii. Upon ~~*submission of the completed individualized treatment plan to the Department or its designee, PSR services may be prior authorized*~~ initiation of treatment at the agency, the treatment plan is valid for no more than one hundred twenty (120) days from the date of discharge from the hospital. ~~*For services to continue beyond one hundred twenty (120) days, the requirements of Section 129 of these rules must be met by the provider agency.*~~ An intake assessment must be completed within ten (10) days of the initiation of treatment. A comprehensive diagnostic assessment must be completed in lieu of the intake assessment if one is not available from the hospital or if the one from the hospital does not contain the needed clinical information. ~~*(3-19-07)*~~( )

b. ~~*A mental health clinic may serve a participant with Enhanced Plan services following a psychiatric hospitalization after a comprehensive assessment has been completed. The assessment*~~ In order for the participant to continue in the services listed on the post-hospitalization treatment plan beyond one hundred twenty (120) days, the provider must establish that the participant meets the criteria as described in Subsections 112.01 through 112.06 of this rule as applicable to the services being provided, and ~~*is*~~ that enhanced outpatient mental health services are appropriate for the participant's age, circumstances, and medically necessary level of care ~~*that is medically necessary*~~. The PSR or mental health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced Plan. ~~*(4-2-08)*~~( )

113. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - INTAKE ASSESSMENT.

Intake assessments may be performed by PSR agencies and Mental Health Clinics for participants who transfer to them from other agencies. Intake assessments must meet requirements listed at IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 710.03. Intake assessments must not be performed as an initial evaluation service in PSR agencies when the PSR agency is performing a comprehensive diagnostic assessment. ( )

11~~3~~4. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - COMPREHENSIVE DIAGNOSTIC ASSESSMENT.
In order to determine eligibility for enhanced outpatient mental health services, a comprehensive diagnostic assessment must first be completed by one (1) of the following licensed professionals: psychiatrist, physician, other practitioner of the healing arts, psychologist, clinical social worker, clinical professional counselor, or licensed marriage and family therapist. For participants seeking services beyond twelve (12) months, a review of the assessment is required to determine whether a full comprehensive diagnostic assessment or an updated assessment is needed to reflect the participant's current status on an annual basis. If, upon this review, the treatment staff determines that the latest assessment accurately represents the status of the participant in the targeted service areas, then the medical record must contain documentation from the treatment staff stating so. In such cases, only an updated assessment that includes a new mental status examination is required. The assessment ~~*must address the participant's strengths and supports, deficits and needs, and must*~~ be directed toward formulation of a diagnosis and a written individualized treatment plan. The participant must take part in the assessment to the fullest extent possible. ~~*The assessment must be directly related to the participant's mental illness and level of functioning. Information regarding services received from any of the participant's service provider(s) must be collected and reported on the comprehensive assessment. The assessment and supplemental psychiatric, psychological, or other specialty evaluations and tests must be written, dated, signed and be retained in the participant's medical record. The assessment is reimbursable if conducted by qualified PSR provider agency staff listed under Section 131 of these rules, or qualified Mental Health Clinic staff listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 715. Each of the following areas must be assessed initially and at least annually thereafter.*~~ The comprehensive diagnostic assessment must include a five (5) axes diagnosis under DSM-IV-TR documented in a face-to-face evaluation, a complete psychiatric and medical history, a current mental status examination, treatment recommendations including level of care, and any other information that contributes to the assessment of the participant's current psychiatric status and need for services. (3-19-07)

~~***01. Psychiatric History and Current Mental Status.*** *Psychiatric history and current mental status which includes, at a minimum:* *(3-19-07)*~~

~~***a.*** *Diagnosis documented within the last twelve (12) months in a face-to-face evaluation by a licensed physician or other licensed practitioner of the healing arts, licensed master's level psychiatric nurse, licensed psychologist, licensed clinical professional counselor, licensed marriage and family therapist, or licensed clinical social worker within the scope of his practice under state law;* *(3-19-07)*~~

~~***b.*** *Age of the participant at onset;* *(3-19-07)*~~

~~***c.*** *Childhood history of physical or sexual abuse;* *(3-19-07)*~~

~~***d.*** *Number of hospitalizations;* *(3-19-07)*~~

~~***e.*** *Precursors of hospitalizations;* *(3-19-07)*~~

~~***f.*** *Symptoms of decompensation the participant manifests;* *(3-19-07)*~~

~~***g.*** *Participant's ability to identify his symptoms;* *(3-19-07)*~~

~~***h.*** *Medication history;* *(3-19-07)*~~

~~***i.*** *Substance abuse history;* *(3-19-07)*~~

~~***j.*** *History of mental illness in the family;* *(3-19-07)*~~

~~***k.*** *Current mental status; and* *(3-19-07)*~~

~~*l. Any other information that contributes to the assessment of the participant's current psychiatric status.* (3-19-07)~~

~~*02. Health or Medical Issues. Medical history and current medical status which includes at a minimum, history of any major non-psychiatric illnesses, surgeries, hospitalizations, dates of last physical, dental, or eye examinations, pertinent family history of medical illness, current health problems or needs, current medications, name of current primary physician; health or medical issues or both including medical complications that result from mental illness.* (3-19-07)~~

~~*03. Vocational And Educational Status. Vocational and educational status which includes at a minimum, current and past job status, level of satisfaction with the vocation, educational level, military status, strengths and barriers to employment. For children, this area addresses relevant school enrollment, performance, achievement levels and school related social functioning.* (3-19-07)~~

~~*04. Financial Status. Financial status which includes at a minimum, adequacy and stability of the participant's financial status, financial difficulties of the participant, resources available, and the participant's ability to manage personal finances.* (3-19-07)~~

~~*05. Social Relationships and Supports. Social relationships and supports which includes, at a minimum, participant's ability to establish/maintain personal support systems or relationships and participant's ability to develop leisure, recreational, or social interests.* (3-19-07)~~

~~*06. Family Status. Family status which includes, at a minimum, the participant's ability or desire to carry out family roles, participant's perception of the support he receives from his family, and the role the family plays in the participant's mental illness. For children this area addresses the child's functioning within the family and the impact of the child's mental illness on family functioning.* (3-19-07)~~

~~*07. Basic Living Skills. Basic living skills which include at a minimum, participant's ability to meet age appropriate basic living skills including transition to adulthood.* (3-19-07)~~

~~*08. Housing. Housing which includes at a minimum, current living situation and level of satisfaction with the arrangement, and appropriateness of current living situation with respect to the participant's needs, his health and safety.* (3-19-07)~~

~~*09. Community and Legal Status. Community and Legal status which includes at a minimum, legal history with law enforcement, transportation needs, supports the participant has in the community, and daily living skills necessary for community living.* (3-19-07)~~

115. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - FUNCTIONAL ASSESSMENT.
For participants seeking the PSR services of skill training and community reintegration and for participants seeking partial care services, a functional assessment must be completed by staff who meet the requirements under Section 131 of these rules. Staff performing the CAFAS/PECFAS must be the same staff completing the functional assessment. Following the completion of the comprehensive diagnostic assessment in which categories of skill training needs are identified, a functional assessment must evaluate the participant's use of critical skills within those identified categories of skill training that are needed for adaptive functioning in the various environments in which he lives. The provider should assess those functional skill areas identified by the participant and the comprehensive diagnostic assessment that prohibit the participant from completing desired tasks in their day-to-day functioning. The functional assessment should include recommendations for training in one (1) or two (2) skills areas from the following list in which the participant is interested in improving his skills. ( )

01. Health or Medical Issues. Focus must be on participant's skills for self-managing health and medical issues including ability to schedule and keep medical appointments, maximize opportunities for communicating health status to medical providers, and adherence to medical regimens prescribed by healthcare providers. ( )

02. Vocational And Educational Status. Focus must be on skill development to maximize adaptive

occupational functioning as applicable to work or school settings. ( )

03. Financial Status. Focus must be on the participant's skills for managing personal finances. ( )

04. Social Relationships and Supports. Focus must be on participant's skills for establishing and maintaining personal support systems or relationships and participant's skills for developing and participating in leisure, recreational, or social interests. ( )

05. Family Status. Focus must be on participant's skills needed to carry out family roles and participate in family relationships. ( )

06. Basic Living Skills. Focus must be on participant's skills needed to perform age-appropriate basic living skills, including transition to adulthood. ( )

07. Housing. Focus must be on participant's skills for obtaining and maintaining safe and appropriate housing. ( )

08. Community and Legal Status. Focus must be on participant's skills necessary for community living including compliance with rules, laws, and informal agreements made with others. ( )

114. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - WRITTEN INDIVIDUALIZED TREATMENT PLAN.
A written individualized treatment plan must be developed and implemented for each participant of enhanced outpatient mental *outpatient* health services as a means to address the enhanced service needs of the participant. Each individualized treatment plan must specify the individual staff person responsible for providing each service, and the amount, frequency and expected duration of treatment. Treatment planning is reimbursable if conducted by a professional identified in Subsections 132.01 through 132.09 of these rules. *(3-19-07).*( )

01. Goals. Services identified on the treatment plan must support the goals of any of the following as applicable to the participant's identified needs: (3-19-07)

a. *PSR* Skill Training. The goal is *the maximum reduction of mental disability and achievement of the highest possible functioning level of that participant; for adults this means becoming independent or maintaining the highest level of independence; for children this means learning or maintaining developmentally appropriate role functioning* to assist the participant in regaining skills that have been lost due to the symptoms of his mental illness so that he may achieve maximum reduction of symptoms of mental illness or serious emotional disturbance for adaptive community living. For a participant who is a child, the targeted skills must be those that would otherwise have been developed except for the interference of the symptoms of SED. *(3-19-07)*( )

b. Community Reintegration. The goal is to provide practical information and support for the participant to be able to be effectively involved in the rehabilitation process. ( )

***b*c.** Partial care. The goal is to decrease the severity and acuity of presenting symptoms so that the participant may be maintained in the least restrictive setting and to increase the participant's interpersonal skills in order to obtain the optimal level of interpersonal adjustment. (3-19-07)

***c*d.** Psychotherapy. The goal is to *develop and implement* engage in active treatment that involves psychotherapeutic strategies for problem resolution to promote optimal functioning and wellness. *(3-19-07)*( )

e. Psychopharmacology. The goal is to obtain a decrease or remission of symptoms of psychiatric illness and improve quality of life through the use of pharmacological agents without causing adverse affects. ( )

02. Plan Content. An individualized treatment plan must *include* meet the *following* requirements listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 709, at a minimum*:*. Additionally, at least one (1) objective is required in the areas that are most likely to lead to the greatest level of stabilization. *(3-19-07)*( )

***a.** An issue statement specifically describing the participant's behavior that directly relates to his*

~~*mental illness and functional impairment;* (3-19-07)~~

~~***b.*** *A statement which identifies the participant's goal relative to the goals of Enhanced Outpatient Mental Health Services as per Sections 120 of these rules;* (3-19-07)~~

~~***c.*** *Overall goals and concrete, measurable objectives to be achieved, including time frames for completion. At least one (1) objective is required for the focus areas which must likely lead to the greatest stabilizing impact. At a minimum, this should include at least one (1) objective in each of the two (2) focus areas which qualify the participant for Enhanced Outpatient Mental Health Services;* (3-19-07)~~

~~***d.*** *Tasks that are specific, time limited activities and interventions designed to accomplish the objectives in the individualized treatment plan and are developed by the participant and the selected provider(s). Each task description must specify the anticipated place of service, the frequency of services, the type of service, and the person(s) responsible to assist the participant in the completion of tasks; and* (3-19-07)~~

~~***e.*** *Documentation of who participated in the development of the individualized treatment plan. The participant, if possible, must take part in the development of the individualized treatment plan. The adult participant or the adult participant's legal guardian must sign the individualized treatment plan or documentation must be provided why this was not possible, including participant refusal to sign. For a minor child participant, the child's parent or legal guardian must sign the plan. A copy of the plan must be given to the adult participant and his legal guardian or to the parent or legal guardian when the participant is a minor child.* (3-19-07)~~

03. **Plan Timeframes**. An individualized treatment plan must be developed and signed by a physician or a licensed practitioner of the healing arts within thirty (30) calendar days from initial contact. Intermittent treatment plan reviews must occur as medically necessary, but must not exceed one hundred twenty (120) days between reviews. The treatment plan must be completely rewritten for participants who will continue in treatment beyond twelve (12) months. ~~(3-19-07)~~( )

~~***04.*** ***Annual Review****. An individualized treatment plan review by the provider agency staff and the participant must occur at least annually. During the review, the provider agency staff and the participant review any objectives which may be added to or deleted from the individualized treatment plan. Input from other participants in the plan including service provider(s) must be considered. Other attendees of the individualized treatment plan review may be chosen by the adult participant or his legal guardian if any or, when the participant is a minor child, by his family or legal guardian and the provider agency staff.* (3-19-07)~~

~~***05.*** ***Physician Review****. Each individualized treatment plan must be reviewed and signed by a physician or a licensed practitioner of the healing arts at least annually. Treatment plans developed by a Mental Health Clinic must be signed by a Medical Doctor (MD) or Doctor of Osteopathy (DO).* (3-19-07)~~

~~***06.*** ***Date of Plan****. Following the completion of the comprehensive assessment and the date the plan is established, that date continues to be the annual date of the plan. Mental health clinics and PSR provider agencies serving the same participant must coordinate services such that the annual review date occurs on the same anniversary date.* (3-19-07)~~

0~~7~~4. **Choice of Providers**. The eligible participant ~~*will*~~ or his legal guardian must be allowed to choose whether or not he desires to receive enhanced outpatient mental health services and ~~*who the*~~ which provider~~*(s) of services will be*~~ agency or agencies he would like to assist him in accomplishing the objectives stated in his individualized treatment plan. Documentation must be included in the participant's medical record showing that the participant or his legal guardian has been informed of his rights to refuse services and choose provider~~s~~ agencies.
~~(3-19-07)~~( )

~~***08.*** ***Authorization Time Period****. PSR Service authorizations are limited to a twelve (12) month period and must be reviewed and updated at least annually.* (3-19-07)~~

0~~9~~5. **No Duplication of Services**. The provider agency or its designee must monitor, coordinate, and jointly plan with all known providers to a participant to prevent duplication of services provided to enhanced outpatient mental health services participants through other Medicaid reimbursable and non-Medicaid programs.

(3-19-07)

115. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES - MENTAL HEALTH CLINICS (MHC).
All rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 707 through 718 apply to Mental Health Clinic services in this chapter with the ~~*following*~~ enhancements described under Section 118 of these rules.
~~*(3-19-07)*~~( )

118. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES -- DESCRIPTIONS.

01. Psychotherapy. Under the Medicaid Enhanced Plan, individual, family and group psychotherapy services are limited to forty-five (45) hours per calendar year. (3-19-07)

02. Partial Care Services. Under the Medicaid Enhanced Plan, partial care services are limited to ~~*thirty-six*~~ twelve (~~36~~12) hours per week per eligible participant. ~~*(3-19-07)*~~( )

a. In order to be considered a partial care service, the service must: (3-19-07)

i. Be provided in a structured environment within the MHC setting; (3-19-07)

ii. Be ~~*a needed service as indicated*~~ identified as a service need through the participant's comprehensive diagnostic assessment ~~*in Section 113 of these rules and Section 114 of these rules*~~ and the functional assessment and be indicated on the individualized treatment plan with documented, concrete, and measurable ~~*goals*~~ objectives and outcomes; and ~~*(3-19-07)*~~( )

iii. Provide interventions for relieving symptoms, stabilizing behavior, and acquiring specific skills. These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives. ~~*(3-19-07)*~~( )

b. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01. (3-19-07)

c. Excluded Services. Services that focus on vocation, recreation or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. (3-19-07)

~~*116.*~~ **119. (RESERVED).**

(BREAK IN CONTINUITY OF SECTIONS)

123. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - DESCRIPTIONS.
~~*The goal of PSR services is to aid participants in work, school, family, community, or other issues related to their mental illness. It is also to aid them in obtaining developmentally appropriate skills for living independently and to prevent movement to a more restrictive living situation.*~~ All services provided must be clinically appropriate in content, service location and duration and based on measurable and behaviorally specific and achievable objectives in accordance with the treatment plan. PSR consists of the following services described in Subsections 123.01 through 123.08 of this rule. ~~*(1-1-08)T*~~( )

01. Pharmacological Management. Pharmacological management services must be provided in accordance with the individualized treatment plan. Pharmacological management, alone, may be provided if the plan indicates that this service is necessary and sufficient to prevent relapse or hospitalization and that functional deficits are either manageable by the participant or absent but expected to return if pharmacological management is not provided. The telephoning of prescriptions to the pharmacy is not a billable service. Medication prescriptions must be ~~*done*~~ issued to the participant in person by a licensed physician or other practitioner of the healing arts within the

scope of practice defined in their license ~~*in visual contact with the participant*~~. ~~*(3-19-07)*~~( )

02. ~~***Individual Psychosocial Rehabilitation (PSR)***~~ **Skill Training**. ~~*Individual psychosocial rehabilitation*~~ Skill training is the service of providing instruction for skill development to the participant in a custom-tailored approach with the goal of increasing the participant's ability to function in the various environments he or his legal guardian choose. The service must be provided in accordance with the objectives specified in the individualized treatment plan. ~~*Individual PSR is a service provided to an individual participant on a one-to-one basis. Individual PSR*~~ Skill training is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications, in accordance with Section 131 of these rules. ~~*Individual PSR*~~ Skill training includes one (1) or more of the following: ~~*(3-19-07)*~~( )

a. Assistance in gaining and utilizing skills necessary to ~~*undertake school, employment, or independence*~~ function adaptively in home and community settings. This includes helping the participant learn personal hygiene and grooming, selecting and acquiring appropriate clothing, ~~*time management and other skills related to participant's psychosocial circumstances;*~~ and other self-care skills needed for community integration. This service cannot be duplicative of other services the participant may be receiving from other programs. ~~*(3-19-07)*~~( )

b. ~~*Ongoing on-site assessment, evaluation, and feedback sessions, including one hundred twenty (120) day reviews, to identify symptoms or behaviors related to the participant's mental illness and to develop interventions with the participant and his employer or teacher;*~~ Assistance in gaining and utilizing skills necessary for managing personal finances, living arrangements, and daily home care duties. ~~*(3-19-07)*~~( )

c. Individual interventions in social skill training directly related to the participant's mental illness to improve ~~*communication skills*~~ community functioning and to facilitate appropriate interpersonal behavior. ~~*directly related to the participant's mental illness;*~~ ~~*(3-19-07)*~~( )

d. ~~*Problem solving, support, and supervision related to activities of daily living to assist participants in gaining and utilizing skills such as personal hygiene, household tasks, use of transportation, and money management;*~~ Assistance in gaining and utilizing cognitive skills for problem-solving everyday dilemmas, listening, symptom management, and self-regulation. ~~*(3-19-07)*~~( )

e. ~~*Assisting the participant with receiving necessary services when he has difficulty or is unable to obtain them.*~~ Assistance for gaining and utilizing communications skills for the participant to be able to express himself coherently to others including other service providers. ~~*(3-19-07)*~~( )

i. ~~*This assistance may be given by accompanying him to Medicaid-reimbursable appointments. For reimbursement purposes, the PSR agency staff person must be present during the appointment and deliver a PSR service during the appointment. Travel time and time waiting to meet with the Medicaid provider are not reimbursable; however, reimbursement is available for the delivery of prior authorized PSR services occurring during these times.*~~ For participants receiving skill training for communication whose current communication functioning is impaired to the extent that he cannot express necessary information to his healthcare providers or understand instructions given to him by healthcare providers, the PSR agency staff person may accompany the participant to medical appointments as a part of the communication skill training service. ~~*(3-19-07)*~~( )

ii. ~~*To be eligible for this service, the participant must have a functional impairment that affects his ability to communicate accurately due to a mental illness and be unable to report symptoms to a licensed practitioner, as identified in Subsection 131.01 of these rules, or be unable to understand the practitioner's instructions. The impairment must be identified in the assessment. The individualized treatment plan must identify how the impairment is to be resolved and include objectives toward independence in this area. For children, this service is not intended to replace the parent's responsibility in advocating for or attending appointments for their child;*~~ For reimbursement purposes, the PSR agency staff person must be present during the appointment and deliver a skill training service during the appointment. Travel time and time waiting to meet with the Medicaid provider are not reimbursable. ~~*(3-19-07)*~~( )

iii. The individualized treatment plan must identify how the impairment is to be resolved and include objectives toward independence in this area. For children, this service is not intended to replace the parent's

responsibility in advocating for or attending appointments for their child; ( )

f. Medication education may be provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating the participant about the role and effects of medications in treating symptoms of mental illness, *and* symptom management, and adherence to the treatment regimen. *(3-19-07)*( )

g. *Development of coping skills and symptom management to identify the symptoms of mental illness that are barriers to successful community integration and crisis prevention.* Assistance for gaining and utilizing skills needed by the participant to arrange for his transportation, or to access and utilize the public transportation system. *(3-19-07)*( )

h. *May assist participant with "self" administration of medications by verbal prompts according to the direction of the prescribing physician. Verbal prompts must be delivered face to face and an assessment of the participant's functioning must be completed and documented. In cases where verbal prompts by phone are justified, they must be specifically prior authorized.* *(3-19-07)*

03. Community Reintegration. Community reintegration is the service of providing practical information and support to a participant to help the participant maintain skills or to practice newly-acquired skills. This type of service may include: ( )

a. Assisting the participant with self-administration of medications by verbal prompts according to the direction of the prescribing physician. Verbal prompts must be delivered face-to-face and an assessment of the participant's functioning must be completed and documented. In cases where verbal prompts by phone are justified, they must be specifically prior authorized. ( )

b. Assisting the participant with maintaining or obtaining services that the participant usually takes care of for himself but is temporarily unable to do so because of an exacerbation of his symptoms. The targeted skills must be necessary to maintain his status in the home or community. ( )

c. Working with the participant's legal guardian immediately following the delivery of a mental health service in order to provide follow-up and support actions that facilitate the participant's positive response to the services. ( )

03*4*. Group *Psychosocial Rehabilitation (PSR)* Skill Training. Group *PSR* skill training must be provided in accordance with the objectives specified in the individualized treatment plan. Group *PSR* skill training is a service provided to two (2) or more individuals concurrently. Group *PSR* skill training is reimbursable if provided by an agency with a current provider agreement and the agency staff person delivering the service meets the qualifications in accordance with Section 131 of these rules. This service includes one (1) or more of the following: *(3-19-07)*( )

a. Medication education groups provided by a licensed physician, licensed nurse, or a licensed practitioner of the healing arts within the scope of his practice under state law. This service focuses on educating participants about the role and effects of medications in treating symptoms of mental illness, *and* symptom management, and skills for adhering to their medical regimen. These groups must not be used solely for the purpose of group prescription writing; *(3-19-07)*( )

b. *Employment or school-related* Community Living skills groups *to* that focus on occupation-related symptom management *on the job or in school*, symptom reduction, and *education about* skills related to appropriate job or school-related behaviors; *(3-19-07)*( )

c. Communication and interpersonal skills groups, the goals of which are to improve communication skills and facilitate appropriate interpersonal behavior; (3-19-07)

d. Symptom management groups to identify mental illness symptoms which are barriers to successful community integration, crisis prevention, problem identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members and other support persons; and

(3-19-07)

e. Activities of daily living groups which help participants learn skills related to personal hygiene, grooming, household tasks, use of transportation, socialization, and money management. (3-19-07)

0~~4~~5. Crisis Intervention Service. Crisis support includes intervention for a participant in crisis situations to ensure his health and safety or to prevent his hospitalization or incarceration. Crisis intervention service is reimbursable if provided by an agency with a current provider agreement and the agency staff delivering the service meet the qualifications under Section 131 of these rules. A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies. PSR agency staff may deliver direct services within the scope of these rules or ~~*link*~~ refer the participant to community resources to resolve the crisis or both. Crisis support may be provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service and the individualized treatment is either authorized the next business day following the beginning of the crisis or prior authorized in anticipation of the need for crisis support. Crisis hours are authorized on a per incident basis. ~~*(1-1-08)T*~~( )

a. Crisis Support in a Community. Limitations to reimbursement in this place of service are described in Subsection 124 of these rules. (3-19-07)

b. Crisis Support in an Emergency Department. (3-19-07)

i. A service provided in a hospital emergency department as an adjunct to the medical evaluation completed by the emergency department physician. This evaluation may include a psychiatric assessment. (3-19-07)

ii. The goal of this service is to assist in the identification of the least restrictive setting appropriate to the needs of the participant. (3-19-07)

0~~5~~6. Collateral Contact. Collateral contact, as defined in Section 010 of these rules, is ~~*covered by Medicaid if*~~ a reimbursable service when it is included on the participant's individualized treatment plan and it is necessary to gather and exchange information~~, provide interpretation or explanation of results of psychiatric evaluations, medical examinations and procedures, other accumulated data to family or other responsible persons,~~ with members of the participant's interdisciplinary team or advise them how to assist the participant.
~~*(1-1-08)T*~~( )

a. Collateral contact may be provided face-to-face by agency staff ~~*qualified to deliver*~~ providing treatment services. Face-to-face contact is defined as two (2) people meeting in person at the same time; or
~~*(1-1-08)T*~~( )

b. Collateral contact may be provided by telephone by agency staff ~~*qualified to deliver*~~ providing treatment services, when this is the most expeditious and effective way to exchange information. ~~*(1-1-08)T*~~( )

0~~6~~7. Nursing Service. A service performed by licensed and qualified nursing personnel within the limits of the Nurse Practice Act, Section 54-1402, Idaho Code. This may include supervision, monitoring, and administration of medications. (3-19-07)

0~~7~~8. Psychotherapy. Individual, group, and family psychotherapy must be ~~*prior authorized and*~~ provided in accordance with the objectives specified in the written individualized treatment plan, as described in Section 11~~4~~5 of these rules. Staff qualified to deliver psychotherapy and qualified supervisors of psychotherapy are identified in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 707 through 718. ~~*(1-1-08)T*~~( )

~~***08. Occupational Therapy**. Occupational therapy services must be prior authorized by the Department, based on the results of an occupational therapy evaluation completed by a licensed Occupational Therapist in accordance with Subsections 131.11 and 140.08 of these rules.* *(1-1-08)T***~~

124. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - COVERAGE AND LIMITATIONS.
The following service limitations apply to PSR services, unless otherwise authorized by the Department in each

region. (3-19-07)

01. Assessment. ~~*Any combination of evaluations or diagnostic services is limited to a maximum of six (6) hours annually.*~~ Assessments must not exceed the following limits: ~~*(3-19-07)*~~( )

a. Intake Assessment. One (1) hour per provider per participant; ( )

b. Comprehensive Diagnostic Assessment. Four (4) hours per participant annually; ( )

c. Functional Assessment. One (1) hour per provider per participant. ( )

02. Individualized Treatment Plan. Two (2) hours per year per participant per provider agency are available for treatment plan development. (3-19-07)

03. Psychotherapy. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. Services beyond six (6) hours must be prior-authorized. ~~*(3-19-07)*~~( )

04. Crisis Intervention Service. A maximum of twenty (20) hours of crisis support in a community may be reimbursed per crisis during any consecutive five (5) day period. Authorization must follow procedure described above at Subsection 123.04 of these rules. (1-1-08)T

05. ~~***Psychosocial Rehabilitation***~~ **Skill Training**. ~~*Any combination of PSR services excluding crisis hours are not to exceed twenty (20) hours per week and must be prior authorized by the Department. Services in excess of twenty (20) hours require additional review and prior authorization.*~~ Services are limited to two (2) hours weekly. Up to five (5) additional weekly hours are available with prior authorization. (3-19-07)

06. Community Reintegration. Services are limited to three (3) hours weekly. Up to ten (10) additional weekly hours are available with prior authorization. ( )

0~~6~~7. Place of Service. PSR agency services are to be home and community-based. ~~*(3-19-07)*~~( )

a. PSR agency services must be provided to the participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the individualized treatment plan and ~~*is prior authorized*~~ is medically necessary to maximize the impact of the service. ~~*(3-19-07)*~~( )

b. PSR agency services may be provided to a participant living in a residential or assisted living facility if the PSR services are determined by the Department to be appropriate, desired by the resident, and are not the responsibility of the facility or another agency under the Negotiated Service Agreement for residential or assisted living facilities. ~~*(3-19-07)*~~( )

c. Prior to delivering any services in a school-based setting, the PSR agency must have a contract with the school or the Infant Toddler program. The PSR agency must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856. (3-19-07)

125. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - EXCLUDED SERVICES NOT REIMBURSABLE UNDER MEDICAID.
Excluded services are those services that are not reimbursable under Medicaid PSR. The following is a list of those services: (3-19-07)

01. Inpatient. Treatment services rendered to participants residing in inpatient medical facilities including nursing homes, or hospitals, except those identified in Subsection 140.09 of these rules. (3-19-07)

02. Recreational and Social Activities. Activities which are primarily social or recreational in purpose. (3-19-07)

03. Employment. Job-specific interventions, job training and job placement services which includes helping the participant develop a resume, applying for a job, and job training or coaching. (3-19-07)

04. Household Tasks. Staff performance of household tasks and chores. (3-19-07)

05. Treatment of Other Individuals. Treatment services for persons other than the identified participant. (3-19-07)

06. ~~*Participant Staffing Within an Agency*~~ Services Primarily Available Through Other Community Agencies. ~~*A participant staffing between two (2) staff who both provide PSR services within the same agency is not reimbursable. A participant staffing may fall under the definition of collateral contact when it is prior authorized and occurs between two (2) staff who are providing services from different Medicaid programs either within or outside the same agency.*~~ Any basic service for the provision of housing, education, social services, or transportation. The PSR agency staff should refer participants to other types of service agencies for these services. ~~*(3-19-07)*~~( )

07. Medication Drops. Delivery of medication only; (3-19-07)

08. Services Delivered on an Expired Individualized Treatment Plan. Services provided between the expiration date of one (1) plan and the start date of the subsequent treatment plan. (3-19-07)

09. Transportation. The provision of transportation services and staff time to transport. (3-19-07)

10. Inmate of a Public Institution. Treatment services rendered to participants who are residing in a public institution as defined in 42 CFR 435.1009. (3-19-07)

11. Services Not Listed. Any other services not listed in Section 123 of these rules. (3-19-07)

126. -- 127. (RESERVED).

128. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - RESPONSIBILITIES OF THE DEPARTMENT.
The Department will administer the provider agreement for the provision of PSR agency services and is responsible for the following tasks: ~~*(3-19-07)*~~( )

01. Credentialing. The Department is responsible for ensuring Medicaid PSR agencies meet credentialing requirements described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 712. (3-19-07)

02. ~~*Individualized Treatment Plan Requirements*~~ Prior Authorization Process. ~~*Individualized treatment plans must include the following:*~~ Reimbursement for specific services that require prior authorization will be authorized from the date the required documentation is received by the Department. The specific documentation that is required for prior authorization is dependent on the request for additional services. ~~*(3-19-07)*~~( )

~~***a.*** *Required Documentation. The required documentation for each individualized treatment plan includes:* *(3-19-07)*~~

~~***i.*** *Participant demographic information;* *(3-19-07)*~~

~~***ii.*** *A comprehensive assessment as provided in Section 113 of these rules;* *(1-1-08)T*~~

~~***iii.*** *A written individualized treatment plan as provided in Section 114 of these rules;* *(1-1-08)T*~~

~~***iv.*** *Adult treatment plans require a mental health client profile; and* *(3-19-07)*~~

~~***v.*** *Children's individualized treatment plans also require the Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS).* *(3-19-07)*~~

~~*b. Receipt of Required Documentation. Reimbursement for services will be authorized from the date the individualized treatment plan and other required documentation are received by the Department. For the annual update, all required documentation must be received by the Department before the expiration date of the current assessment and plan. In order for a prior authorization to remain valid throughout the treatment plan year, documentation of the one hundred twenty (120) day reviews must comply with Subsection 136.05 of these rules.*~~ ~~*(3-19-07)*~~

~~*c*~~a. Hours and Type of Service. The Department must authorize the number of hours and type of services which could be reasonably expected to lead to achievement of the individualized treatment plan objectives. (3-19-07)

~~*d*~~b. Authorization Time Period. ~~*Service*~~ Prior authorizations are limited to a ~~*twelve*~~ six (~~*12*~~6) month period and must be reviewed and updated ~~*at least annually*~~ to continue. ~~*(3-19-07)*~~( )

03. Notice of Decision. At the point the Department makes a decision that a participant is ineligible for PSR agency services, a notice of decision citing the reason(s) the participant is ineligible for PSR agency services must be issued by the Department. The notice of decision must be sent to the adult participant and a copy to his legal guardian, if any. When the participant is a minor child, the notice of decision must be sent to the minor child's parent or legal guardian. ~~*(3-19-07)*~~( )

04. Increases in Individualized Treatment Plan Hours or Change in Service Type. When the Department is notified, in writing, by the provider of recommended increases in hours or change in type of service provided, the Department must review the request and either approve or deny the request within ~~*ten*~~ fifteen (1~~0~~5) working days of receipt. A clear rationale for the increase in hours or change in service type must be included with the request. ~~*(3-19-07)*~~( )

05. Changes to Individualized Treatment Plan Objectives or Tasks. When a provider believes that an individualized treatment plan needs to be revised without increasing hours or changing type of service, the provider should amend the individualized treatment plan at the time of the next one hundred twenty-day (120) review or when substantial changes in the participant's mental status or circumstances require immediate changes in the plan objectives. The amended individualized treatment plan must be retained in the participant's record and submitted to the Department upon request. (3-19-07)

06. Service System. The Department is responsible for the development, maintenance and coordination of regional, comprehensive and integrated service systems. (3-19-07)

129. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - PROVIDER RESPONSIBILITIES

01. Provider Agreement. Each provider must enter into a provider agreement with the Division of Medicaid for the provision of PSR agency services and also is responsible for the following tasks: ~~*(3-19-07)*~~( )

02. Service Provision. Each provider must have signed additional terms to the general provider agreement with the Department. (3-19-07)

03. Service Availability. Each provider must assure provision of PSR agency services to participants on a twenty-four (24) hour basis. ~~*(3-19-07)*~~( )

04. Comprehensive Diagnostic Assessment and Individualized Treatment Plan Development. The provider agency is responsible to conduct a comprehensive diagnostic assessment and develop an individualized treatment plan for each participant with input from the interdisciplinary team if these services have not already been completed by another provider. In the event the agency makes a determination that it cannot serve the participant, the agency must make appropriate referrals to other agencies to meet the participant's identified needs. ~~*(3-19-07)*~~( )

05. Individualized Treatment Plan. The provider must develop an individualized treatment plan in accordance with Section 11~~4~~5 of these rules. The signature of a physician, or other licensed practitioner of the healing arts within the scope of his practice under state law is required on the individualized treatment plan indicating the

services are medically necessary. The date of the initial plan is the date it is signed by the physician. ~~*Reimbursement for services will be authorized according to Subsection 128.02.b. of these rules.*~~ ~~*(3-19-07)*~~( )

06. Changes to Individualized Treatment Plan Objectives. When a provider believes that an individualized treatment plan needs to be revised, the provider should ~~*include that recommendation and rationale in the documentation for the next one hundred twenty (120) day review*~~ make those revisions in collaboration with the participant's interdisciplinary treatment team and obtain authorizing signatures. Amendments and modifications to the treatment plan objectives must be justified and documented in the medical record. ~~*(3-19-07)*~~( )

07. Effectiveness of Services. Effectiveness of services, as measured by a participant's achievement of his plan objectives, must be monitored by the provider and changes to the individualized treatment plan must be initiated when service needs change or interventions are shown to be ineffective. These measures must be included on the participant's one hundred twenty (120) day review. (3-19-07)

08. Healthy Connections Referral. Providers must obtain a Healthy Connections referral if the participant is enrolled in the Healthy Connections program. (3-19-07)

130. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - PROVIDER AGENCY REQUIREMENTS.
Each agency that enters into a provider agreement with the Department for the provision of PSR services must meet the following requirements: (3-19-07)

01. Agency. A PSR agency must be a proprietorship, partnership, corporation, or other entity, employing at least two (2) staff qualified to deliver PSR services under Section 131 of these rules, and offering both ~~*PSR services*~~ direct and administrative services. Administrative services may include such activities as billing, hiring staff, assuring staff qualifications are met and maintained, setting policy and procedure, payroll. ~~*(3-19-07)*~~( )

02. Criminal History Checks. (3-19-07)

a. The agency must verify that all employees, subcontractors, or agents of the agency providing direct care or PSR services have complied with IDAPA 16.05.06, "Criminal History and Background Checks." (3-19-07)

b. Once an employee, subcontractor, or agent of the agency has completed a self-declaration form and has been fingerprinted, he may begin working for the agency on a provisional basis while awaiting the results of the criminal history check. (3-19-07)

c. Once an employee, subcontractor, agent of the agency has received a criminal history clearance, any additional criminal convictions must be reported to the Department when the agency learns of the conviction. (3-19-07)

03. PSR Agency Staff Qualifications. The agency must assure that each agency staff person delivering PSR services meets at least one (1) of the qualifications in Section 131 of these rules. (3-19-07)

04. Additional Terms. The agency must have signed additional terms to the general provider agreement with the Department. The additional terms must specify what ~~*PSR*~~ direct services must be provided by the agency. The agency's additional terms may be revised or cancelled at any time. ~~*(3-19-07)*~~( )

05. Agency Employees and Subcontractors. Employees and subcontractors of the agency are subject to the same conditions, restrictions, qualifications and rules as the agency. (3-19-07)

06. Supervision. The agency must provide staff with adequate supervision to insure that the tasks on a participant's individualized treatment plan can be implemented effectively in order for the individualized treatment plan objectives to be achieved. Individuals in Subsection 131.08 through 131.1~~2~~1 of these rules must be supervised by individuals in Subsection 131.01 through 131.07 of these rules. ~~*(3-19-07)*~~( )

a. Case-specific supervisory contact must be made weekly, at a minimum, with staff for whom supervision is a requirement. Documentation of supervision must be maintained by the agency and be available for

review by the Department. (3-19-07)

b. An agency must assure clinical supervision is available to all staff that provide psychotherapy. The amount of supervision should be adequate to ensure that the individualized treatment plan objectives are achieved. Documentation of supervision must be maintained by the agency and be available for review by the Department. (3-19-07)

c. The physician must review and sign the individualized treatment plan as an indicator that the services are medically necessary and prescribed; and ( )

07. Staff-to-Participant Ratio. The following treatment staff-to-participant ratios for group treatment services must be observed: ( )

a. For children under six (6) years of age, the ratio must be 1:1. No group work is allowed. ( )

b. For children six (6) to twelve (12) years of age, the ratio must be 1:6 for groups. Group size must not exceed twelve (12) participants. ( )

c. For children over age twelve (12) years of age, the ratio must be 1:10 ratio for groups. Group size must not exceed twelve (12) participants. ( )

08. Family Participation Requirement. The following standards must be observed for services provided to children: ( )

a. For children under six (6) years of age, the participant's legal guardian must be present during the delivery of mental health services. The legal guardian does not have to participate in the treatment session, but must be present and available for consultation with the staff providing the service. Services are to be provided in the home whenever possible. ( )

b. For children six (6) to twelve (12) years of age, the participant's legal guardian must be actively involved. The legal guardian does not have to participate in the treatment session but must be present and available for consultation with the staff providing the service; ( )

c. For children over age twelve (12) years of age, the participant's legal guardian may participate as appropriate. If the interdisciplinary team recommends that the legal guardian not be involved in any aspect of the treatment, then the reasons for excluding the legal guardian must be documented in the medical record. ( )

0~~7~~9. Continuing Education. The agency must assure that all staff complete twenty (20) hours of continuing education annually from the date of hire. Four (4) hours every four (4) years must be in ethics training. Staff who are not licensed must select the discipline closest to their own and use the continuing education standards attached to that professional license. Nothing in these rules will affect professional licensing continuing education standards and requirements set by the Bureau of Occupational Licenses. (3-19-07)

~~08~~10. Crisis Service Availability. PSR agencies must provide twenty-four (24) hour crisis response services for their participants or make contractual arrangement for the provision of those services. (3-19-07)

11. Restraints and Seclusion. Restraints and seclusion must only be used when the participant's behavior poses a threat of physical harm to himself or others. If an agency intends to use restraints to deal with maladaptive participant behavior the following conditions must be in place: ( )

a. Use of physical prompts, restraints, and seclusion to manage maladaptive participant behavior must be incorporated into the participant's individualized treatment plan. ( )

b. The agency must develop and implement written policies and procedures outlining: ( )

i. Medical necessity of restraints; ( )

ii. Conditions or triggers which will prompt use of restraints; ( )

iii. Type(s) of restraints which will be used; ( )

iv. How long a restraint may be used; ( )

v. Treatment staff in the clinic who will be authorized to employ restraints; ( )

vi. The training or certification of staff qualified to employ restraints; ( )

vii. How the agency will monitor use of restraints so as to not result in physical, mental, or emotional injury to the participant; and ( )

viii. Agency notification requirements for use of restraints to include notification of the participant's parent or legal guardian, and physician. ( )

c. The agency will complete an incident report for each use of restraints documenting the following: ( )

i. Type of restraint; ( )

ii. Restraint start time; ( )

iii. Triggering condition or behavior; ( )

iv. Staff member employing restraint; ( )

v. Restraint end time; ( )

vi. Participant response to the restraint intervention; and ( )

vii. Alternate methods attempted and results prior to the use of restraints or seclusion. ( )

d. Following the use of restraints or seclusion, a behavior modification plan must be developed by a qualified staff person and approved by the interdisciplinary team. ( )

e. Restraints or seclusion cannot be used for punishment, staff convenience, or lack of staff's ability to manage the participant's behavior. ( )

f. Adversive techniques or interventions are not allowed under any circumstances. ( )

***09*12. Building Standards, Credentialing and Ethics**. PSR agencies whose participants are in the agency building for any reason and any amount of time must follow the rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 712 and 714. *(3-19-07)*( )

131. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - AGENCY STAFF QUALIFICATIONS. All agency staff delivering ***PSR*** direct services must meet at least one (1) of the following qualifications: *(3-19-07)*( )

01. Licensed Physician or Psychiatrist. A physician, psychiatrist, or other licensed practitioners of the healing arts within the scope of his practice under state law must be licensed in accordance with Title 54, Chapter 18, Idaho Code, to practice medicine. A licensed practitioner of the healing arts in Idaho may include Physician Assistants and Nurse Practitioners. (3-19-07)

02. Licensed Master's Level Psychiatric Nurse. A certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner, must be licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (3-19-07)

03. Licensed Psychologist. A psychologist must be licensed in accordance with Title 54, Chapter 23, Idaho Code. (3-19-07)

04. Licensed Clinical Professional Counselor or Licensed Professional Counselor. A clinical professional counselor or professional counselor must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (3-19-07)

05. Licensed Marriage and Family Therapist or Licensed Associate Marriage and Family Therapist. A marriage and family therapist must be licensed in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." ~~(3-19-07)~~( )

06. Licensed Masters Social Worker or Licensed Clinical Social Worker. A masters social worker (LMSW) or clinical social worker (LCSW), must hold a license in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (3-19-07)

07. Clinician. A clinician must hold a master's degree, be employed by a state agency and meet the minimum standards established by the Idaho State Division of Human Resources and the Idaho Department of Health and Welfare Division of Human Resources. (3-19-07)

08. Licensed Social Worker. A social worker must hold a license in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (3-19-07)

09. Licensed Professional Nurse (RN). A licensed professional nurse or RN, must be licensed in accordance with Title 54, Chapter 14, Idaho Code. (3-19-07)

~~***10. Psychosocial Rehabilitation (PSR) Specialist**. A PSR specialist must hold at least a bachelor's degree from a nationally accredited university or college in behavioral science, education, or medicine. A PSR specialist must have at least twenty-one (21) semester credit hours (or quarter hour equivalent) in human service fields such as psychology, social work, special education, counseling, and psychosocial rehabilitation. An individual who has been denied licensure, or who is qualified to apply for licensure to the State of Idaho, Bureau of Occupational Licenses in the professions identified in Subsections 131.01 through 131.10 of this rule, is not eligible to provide services under the designation of Psychosocial Rehabilitation Specialist. Individuals approved as PSR specialists under previous rules in this section will be able to continue as qualified PSR specialists as long as they continue to work in the same agency as they did prior to the effective date of this rule. (3-19-07)~~

~~***11. Licensed Occupational Therapist**. An occupational therapist must be licensed in accordance with Title 54, Chapter 37, Idaho Code, and IDAPA 22.01.09, "Rules for the Licensing of Occupational Therapists and Occupational Therapist Assistants." Training and experience in a mental health setting are required. (3-19-07)~~

1~~2~~0. Psychologist Extender. A psychologist extender must work under the supervision of a licensed psychologist and be registered with the Bureau of Occupational Licenses. A copy of that registration must be retained in the extender's personnel file. (3-19-07)

11. Psychosocial Rehabilitation (PSR) Specialist. ( )

a. As of June 30, 2009, persons who are working as PSR Specialists delivering Medicaid-reimbursable mental health services may continue to do so until January 1, 2012, at which time they must be certified as PSR Specialists in accordance with USPRA requirements. ( )

b. As of July 1, 2009, applicants to become PSR Specialists delivering Medicaid-reimbursable mental health services must either have: ( )

i. The training, education, and experience required to sit for the USPRA PSR Specialist certification examination; or ( )

ii. A bachelor's degree from a nationally-accredited university in Primary Education, Special Education, Adult Education, Counseling, Human Services, Early Childhood Development, School Psychology, or a Masters degree in Psychology. ( )

c. As of January 1, 2012, all PSR Specialists delivering Medicaid-reimbursable mental health services must be certified in accordance with USPRA requirements. ( )

132. -- 135. (RESERVED).

136. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - RECORD REQUIREMENTS FOR PROVIDERS.
In addition to the development and maintenance of the individualized treatment plan, the following documentation must be maintained by the provider of PSR services: (3-19-07)

01. Name. Name of participant. (3-19-07)

02. Provider. Name of the provider agency and the agency staff person delivering the service. (3-19-07)

03. Date, Time, Duration of Service, and Justification. Documentation of the date, time, and duration of service, and the justification for the length of time which is billed must be included in the record. (3-19-07)

04. Documentation of Progress. The written description of the service provided, the place of service, and the response of the participant must be included in the progress note. A separate progress note is required for each contact with a participant. (3-19-07)

05. ~~*One Hundred Twenty Day*~~ Treatment Plan Review. A documented review of progress toward each individualized treatment plan goal and objective must be kept in the participant's file. These reviews should occur intermittently, but not more than one hundred twenty (120) days apart. ~~*(3-19-07)*~~( )

a. A copy of the review must be sent to the Department upon request. Failure to do so may result in the loss of a prior authorization or result in a recoupment of reimbursement provided for services delivered after the ~~*one hundred twenty (120) day*~~ intermittent staffing review ~~*due*~~ date. ~~*(3-19-07)*~~( )

b. The review must also include a reassessment of the participant's continued need for services. The review must occur at least every one hundred twenty (120) days and be conducted in visual contact with the participant. For children, the review must include a new CAFAS/PECFAS for the purpose of measuring changes in the participant's functional impairment. ~~*(3-19-07)*~~( )

c. After eligibility has been determined, subsequent CAFAS/PECFAS scores are used to measure progress and functional impairment and should not be used to terminate services. (3-19-07)

06. Signature of Staff Delivering Service. The legible, dated signature, with degree credentials listed, of the staff person delivering the service. (3-19-07)

07. Choice of Provider. Documentation of the participant's choice of provider must be maintained in the participant's file prior to the implementation of the individualized treatment plan. (3-19-07)

08. Closure of Services. A discharge summary must be included in the participant's record and submitted to the Department identifying the date of closure, reason for ending services, progress on objectives, and referrals to supports and other services. (3-19-07)

09. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments ~~*with the Medicaid service coordinator*~~ for any purpose, transporting participants, or documenting services. For services paid at the fifteen (15)

minute incremental rate, providers ~~*will not be reimbursed for more than one (1) contact during a single fifteen (15) minute time period*~~ must comply with Medicaid billing requirements. ~~*(3-19-07)*~~( )

137. - 139. (RESERVED).

140. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - PROVIDER REIMBURSEMENT.
Payment for PSR agency services must be in accordance with rates established by the Department. The rate paid for services includes documentation. ~~*(3-19-07)*~~( )

01. Duplication. Payment for services must not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-19-07)

02. Number of Staff Able to Bill. Only one (1) staff member may bill for an assessment, individualized treatment plan, or case review when multiple ~~*PSR*~~ agency staff are present. ~~*(3-19-07)*~~( )

03. Medication Prescription and Administration. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18, Idaho Code. (3-19-07)

04. Recoupment. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules must be cause for recoupment of payments for services, sanctions, or both. (3-19-07)

05. Access to Information. Upon request, the provider must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request must result in termination of the Medicaid PSR Provider Agreement. (3-19-07)

06. Evaluations and Tests. Evaluations and tests may be provided as a reimbursable service in conjunction with the assessment. (3-19-07)

07. Psychological Evaluations. Psychological evaluations are reimbursable if provided in accordance with the requirements in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 707 through 718. (3-19-07)

~~***08. Evaluations by Occupational Therapists**. Evaluations performed by qualified licensed occupational therapists, performed in conjunction with development of an individualized treatment plan are reimbursable.* *(3-19-07)*~~

0~~9~~8. Psychiatric or Medical Inpatient Stays. Community reintegration ~~*S*~~services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those services included in the responsibilities of the inpatient facility. Treatment services are the responsibility of the facility. ~~*(3-19-07)*~~( )

~~1~~09. Reimbursement for Services Provided in a School. PSR Services provided by a PSR agency in a school-based setting, must be billed by the school district, charter school, or the Idaho Infant Toddler program. (3-19-07)

141. - 145. (RESERVED).

146. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - QUALITY OF SERVICES.
The Department must monitor the quality and outcomes of PSR agency services provided to participants, in coordination with the Divisions of Medicaid, Management Services, and Behavioral Health. ~~*(3-19-07)*~~( )