

Idaho

Data as of April 2004

Mental Health and Substance Abuse Services in Medicaid and SCHIP in Idaho

As of July 2003, 157,062 people were covered under Idaho's Medicaid and SCHIP programs. There were 146,108 enrolled in the Medicaid program, and 10,954 enrolled in the Medicaid SCHIP expansion program. In state fiscal year 2000, Idaho spent \$172 million to provide Medicaid services.

In Idaho low-income children may be enrolled into the Medicaid program or a SCHIP Medicaid expansion program.

- Medicaid covers children up to age 5 from families with incomes of 133% of FPL or less, and children age 6 through 18 from families with incomes of up to 100% of FPL.
- The SCHIP Medicaid expansion program serves all children through age 18 from families with incomes of no more than 150% FPL who do not otherwise qualify for Medicaid.

Idaho requires most beneficiaries in most parts of the state to enroll into their primary care case management (PCCM) program. Those enrolled into the PCCM program must obtain a referral from their PCCM provider before accessing mental health and substance abuse services. Those who do not belong to the PCCM program obtain mental health and substance abuse services through the fee-for-service system and do not need an authorization from a PCCM provider. As of July 2003, there were about 157,062 Medicaid and SCHIP participants. 104,323 of these were enrolled into the PCCM program and 52,739 from fee-for-service.

Medicaid

Who is Eligible for Medicaid?

Families and Children

1. Low-income families who meet the eligibility criteria for Medicaid for Low Income Families based on policies in effect for the AFDC program as it existed on July 16, 1996.
2. Pregnant women, infants and children up to age six in families with incomes of no more than 133% FPL.
3. Children aged 6-18 in families with incomes of no more than 100% FPL.
4. Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act
5. Incapacitated parents

Aged, Blind, and Disabled

1. All individuals receiving SSI or Idaho's supplementary payment.
2. All individuals between the ages of 16 and 64 who meet the SSI definition of disability.
3. Aged, Blind, and Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
4. Individuals who have been in institutions for at least 30 consecutive days and who have incomes of no more than 300% of the maximum SSI benefit.

Medically Needy

Idaho does not have a Medically Needy program.

Waiver Populations

Idaho does not have 1115 waiver.

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What Mental Health/Substance Abuse Services are Covered by Medicaid?

Medicaid must cover some types of services (mandatory services) and may cover some other types of services (optional services). The information presented here identifies the types of service Idaho Medicaid covers and the coverage requirements for those services. These services are presented grouped as they are in the Medicaid State plan that Idaho must maintain under Medicaid law. Only those types of services that include mental health or substance abuse services are discussed.

Mandatory State Plan Services

Inpatient Hospital Services		
Service	Description	Coverage Requirements
Inpatient mental health and substance abuse	Mental health and substance abuse services provided in an inpatient general acute care hospital setting, including psychiatric and chemical dependency care	<ul style="list-style-type: none"> • Treatment must be determined to be medically necessary. • All admissions for psychiatric and chemical dependency treatment require prior authorization from the Medicaid agency's designated agent and are subject to concurrent review .

Outpatient Hospital Including Rural Health Center and Federally Qualified Health Center Services		
Service	Description	Coverage Requirements
Outpatient Psychiatric and Substance Abuse Care	Services, including Medicaid-covered mental health and substance abuse services, performed in the hospital for a client who does not require inpatient accommodations.	<ul style="list-style-type: none"> • Procedures generally accepted by the medical community and which are medically necessary may not require prior approval. • Beneficiaries may not receive more than the following amounts of service without prior authorization from the Medicaid agency <ul style="list-style-type: none"> – Emergency services are limited to 6 visits per year. – Psychotherapy services are limited to 45 hours per year. – Partial care services are limited to 56 hours per year.
Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)	Substance abuse and mental health services that would be covered in another setting may be provided by FQHCs and RHCs	Services provided in an FQHC or RHC setting must meet the same coverage requirements as those delivered in another setting

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Physician Services		
Service	Description	Coverage Requirements
Physician Services	Medicaid-covered mental health and substance abuse services provided by a physician acting within his scope of practice as defined in state licensure, including psychiatric care	<ul style="list-style-type: none"> • Beneficiaries may receive no more than the following amounts of psychiatric services without the prior authorization of the Medicaid agency: <ul style="list-style-type: none"> – 12 hours of psychiatric evaluations in a calendar year. – 45 hours of group or individual psychotherapy sessions per calendar year • Beneficiaries may receive mental health and substance abuse services from a physician as long as the services <ul style="list-style-type: none"> – Is within the physician's scope of practice – Would be covered by Medicaid if provided by another type of provider

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to Children Under 21		
Service	Description	Coverage Requirements
EPSDT Services, called Health Check.	Provides services determined medically necessary as a result of screening that are in excess of any state plan limitations.	<ul style="list-style-type: none"> • The beneficiary must be under 21 years of age • The service must be needed to treat or ameliorate a condition identified in an EPSDT screen • Beneficiaries must receive prior authorization from the Medicaid agency in order to receive services in amounts greater than those otherwise allowed under Medicaid. • In order to receive a service that is not otherwise covered under Medicaid the service must be <ul style="list-style-type: none"> – authorized by a physician, – certified as medically necessary – the least costly alternative to meeting the child's needs, and – prior authorized by the Medicaid agency

Optional State Plan Services

Clinic Services		
Service	Description	Coverage Requirements
Mental health clinics	Services provided in a mental health clinic, including the following <ul style="list-style-type: none"> • Evaluation and diagnosis • Psychological testing • Psychotherapy including individual, group, or family psychotherapy • Partial care (day treatment) • Pharmacological Management • Nursing Services • Crisis Counseling (Emergency Psychotherapy) • *Note – Individuals may receive individual and group psychotherapy as well as pharmacologic management for treatment of substance 	<ul style="list-style-type: none"> • A beneficiary may receive no more than the following amounts of therapy without the prior authorization of the Medicaid agency: <ul style="list-style-type: none"> – 12 hours for a combination of any evaluative or diagnostic services per calendar year; – 45 hours per calendar year of psychotherapy services, – 56 hours per calendar year of partial treatment. • All services must be authorized in a treatment plan approved by a licensed physician.

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Clinic Services		
Service	Description	Coverage Requirements
	abuse disorders in a mental health clinic	

Inpatient Psychiatric Services (for persons under the age of 21)		
Service	Description	Coverage Requirements
Inpatient psychiatric facility services for individuals under 22 years of age	Psychiatric services provided in a free-standing psychiatric hospital.	<ul style="list-style-type: none"> • In order to receive services the beneficiary <ul style="list-style-type: none"> – under 21 years of age at the time of admission; and – have a DSM IV diagnosis with substantial impairment in thought, mood, perception or behavior. – Require a level of care that cannot be provided in a less restrictive setting. • The Department or its designee must authorize admissions. <ul style="list-style-type: none"> – Elective (planned, non-emergency) admissions must be authorized before admission – Emergency admissions require authorization within one workday of the admission

Rehabilitative Services		
Service	Description	Coverage Requirements
Psychosocial Rehabilitation Services	<ul style="list-style-type: none"> • Psychosocial Rehabilitation (PSR) services provided through the State Mental Health Authority in each region. • Covered services include <ul style="list-style-type: none"> – evaluation and diagnostic services, – psychotherapy, – crisis support, – Rehabilitation – Pharmacological Management – Nursing Services – Crisis Intervention • Specific opioid treatments, such as methadone and/or LAAM are not covered 	<ul style="list-style-type: none"> • Prior Authorization is required for all Rehabilitative Mental Health services and may be obtained from the Regional Mental Health Authority (RMHA) • To be eligible for services beneficiaries must be: <ul style="list-style-type: none"> – A child with a serious emotional disturbance (SED) – A person who is 18 years of age or older with a diagnosis of severe and persistent mental illness that directly impacts at least two identified functional areas • Beneficiaries may not receive more than the following amounts of service without the prior authorization of the Medicaid agency or the RMHA. <ul style="list-style-type: none"> – 6 hours in a calendar year of any combination of evaluation or diagnostic services – 24 hours in a calendar year of individual, family and group psychotherapy services. – Community crisis support services are limited to a maximum of 5 consecutive days and must be prior authorized by the Division of Family and Community Services. – 20 hours per week of individual and group psychosocial rehabilitation services that must be prior authorized by the Division of Family and Community Services. (Services in excess of 20 hours require additional

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Rehabilitative Services		
Service	Description	Coverage Requirements
		<ul style="list-style-type: none"> review and prior authorization by the Regional Mental Health Authority) <ul style="list-style-type: none"> – All services must also be identified as medically necessary in a treatment plan approved by a licensed physician or a licensed practitioner of the healing arts
School District/Infant Toddler Program (ITP) Services	<ul style="list-style-type: none"> • Rehabilitative and health related services provided by specified school districts and Infant Toddler Programs • Covered services include: <ul style="list-style-type: none"> – Annual IEP/IFSP plan development – Developmental evaluation/therapy – Intensive Behavioral Intervention – Psychological evaluation/therapy – Psychosocial rehabilitation evaluation 	<ul style="list-style-type: none"> • To be eligible for these services, a beneficiary must: <ul style="list-style-type: none"> – Be identified as <ul style="list-style-type: none"> ▪ a student with an educational disability and be eligible for special education or, ▪ a child age 0-3 years of age, be identified as needing early intervention services due to a developmental delay or disability, and be eligible for the Infant Toddler Program – Have an individual educational plan (IEP) or individual family service plan (IFSP) or service plan (SP) which indicates the need for the service. – Be less than 22 years of age. – Be served by a school district, Infant Toddler Program, or a cooperative-service agency
Developmental Disabilities Agency	<ul style="list-style-type: none"> • Rehabilitative services provided by developmental disabilities agencies (DDAs) that are consistent with the needs of persons with developmental disabilities • Specific services that can be covered include: <ul style="list-style-type: none"> – Individual, group, family, and interactive psychotherapy • Vocational, recreational, and educational services are not covered 	<ul style="list-style-type: none"> • Beneficiaries may only receive services as part of an Individual Support Plan (ISP) developed by a targeted service coordinator (TSC) or under an Individual Program Plan (IPP) • Adults may only receive these services with the prior authorization of the Regional Medicaid Services (RMS) unit. • No beneficiary may receive more than the following amounts of service without the prior authorization of the Medicaid agency <ul style="list-style-type: none"> – 12 hours combined of evaluation or diagnostic services per calendar year. – 45 hours of psychotherapy in a calendar year

Targeted Case Management		
Service	Description	Coverage Requirements
Targeted Case Management (TCM) for SED children	<p>Services to assist eligible individuals to gain access to needed medical, social, educational, and mental health and other services. Services include</p> <ul style="list-style-type: none"> • Assessment • Service plan development and implementation • Crisis assistance • Linking/coordination of services 	<p>To qualify for TCM services</p> <ul style="list-style-type: none"> • a beneficiary must be a child with a severe emotional/behavioral disorder expected to last at least a year; and • have one(1) or more of the following problems associated with their diagnosis: <ul style="list-style-type: none"> – The condition requires multiple services providers and treatments – the condition has resulted in a level of functioning below age norm in 1 or more life areas, such as school, family, or community; or – there is risk of out-of-home placement or – the child is returning from an out-of-home

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Targeted Case Management		
Service	Description	Coverage Requirements
		<ul style="list-style-type: none">- placement as a result of the condition; or there is imminent danger to the safety or ability to meet basic needs of the child as a result of the condition; or- Further complications may occur as a result of the condition without provision of services coordination services; and the family needs a service coordinator to assist them to access medical and other services for the child.
Targeted case management for adults with a severe and persistent mental disorder	Services to assist eligible individuals to gain access to needed medical, social, educational, and mental health and other services. Services include <ul style="list-style-type: none">• Assessment• Service plan development and implementation• Crisis assistance• Linking/coordination of services	To qualify for TCM services a beneficiary must <ul style="list-style-type: none">• be 18 years old or older• be diagnosed with a severe disabling mental illness• Have functional limitations due to the mental illness• Have a history of using high cost medical services

SCHIP Medicaid Expansion Program

Who is Eligible for the SCHIP Medicaid Expansion Program?

The SCHIP Medicaid expansion program serves

1. Children age 0-5 from families with incomes from 133-150% FPL, and
2. Children age 6-18 from families with incomes from 100-150% FPL.

What Mental Health/Substance Abuse Services are Covered by the SCHIP Medicaid Expansion Program?

Service coverage in the SCHIP Medicaid Expansion Program is identical to coverage in the Medicaid program, which was described previously.

Separate SCHIP Program

Idaho has no Separate SCHIP Program