Optum

Frequently Asked Questions
Youth Empowerment Services

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Youth Empowerment Services

Q1. ***What is the Youth Empowerment Services Program? (Revised July 2023)***

A1. The YES Program refers to a type of Medicaid eligibility made possible via the 1915(i) State Plan Amendment. It allows for access to Medicaid-paid respite and higher income limits. Medicaid members who have gone through the independent assessment process and have a qualifying DSM-V mental health diagnosis and substantial functional impairment may qualify for YES Program eligibility if their family income is below 300% of the FPG. Youth Empowerment Services Program members are Medicaid members who have gone through the independent assessment process, have a qualifying DSM-V Mental Health Diagnosis and substantial functional impairment. The Youth Empowerment Services Program is part of the YES System of Care.

Q2. ***What is the 1915(i) State Plan Amendment?***

A2. The 1915(i) State Plan Amendment is an amendment to the Medicaid State Plan used to set specific eligibility standards and services for a select population. It allows Medicaid to extend eligibility income levels and to reimburse providers for services that are not included in the state plan, such as Respite. The 1915(i) State Plan Amendment went into effect on January 1, 2018.

Q3. ***How is the YES System of Care different from the Youth Empowerment Services Program?***

A3. The YES System of Care refers to the entirety of the mental health supports and resources for children and adolescents in Idaho. The YES System of Care requires provider adherence to the YES Practice Model and the YES Principles of Care for all child and adolescent members they serve. All children and adolescent mental health services are part of the YES System of Care.

The Youth Empowerment Services Program refers to a specific population within the YES System of Care. These are individuals who are eligible for Medicaid under the 1915(i) State Plan Amendment. In order to be eligible for Medicaid under the 1915(i) State Plan Amendment, individuals must undergo

an independent assessment with Liberty Healthcare. Liberty Healthcare will determine if the child or adolescent has a serious emotional disturbance (SED).

When Liberty Healthcare determines that the individual has an SED, those who did not previously qualify for Medicaid will then apply for Medicaid with higher income limits. If Medicaid eligibility is approved, these members may receive Medicaid-funded services. A member who was already Medicaid eligible before the independent assessment is also considered to be a part of the Youth Empowerment Services Program and can access services that are available only in the 1915(i) State Plan Amendment which is currently respite.

Q4. ***Who is eligible for the Youth Empowerment Services Program? (Revised July 2023)***

A4. To qualify for the YES Program, a youth must have an independent assessment completed by Liberty Healthcare. The assessment includes the Child and Adolescent Needs and Strengths (CANS) assessment and a Comprehensive Diagnostic Assessment (CDA). If these assessments determine the youth has an SED, the family can then apply for Medicaid, if they are not already enrolled. Once approved for Medicaid and enrolled in the YES Program, the youth must meet CMS requirements to remain enrolled in the program.

Q5. ***How can I tell if a child is part of the Youth Empowerment Services Program when checking their Medicaid eligibility? (Revised April 2022)***

A5. A member who is part of the Youth Empowerment Services (YES) Program can be identified in Provider Express under the eligibility section "Idaho Yes," which will either say "Yes" or "No," identifying whether the member is part of the YES Program. For detailed instructions, please refer to the Identifying Member YES Eligibility section in the TCC Toolkit, which is located at optumidaho.com > For Network Providers > Targeted Care Coordination > Targeted Care Coordination Toolkit.

Q6. ***Is there a specific Idaho Administrative Procedure Act (IDAPA) rule related to YES Services?***

A6. Rules for the YES Program can be found in IDAPA 16.03.10.635-638.

Q7. ***Is there a registration process that providers need to complete in order to provide YES services?***

A7. No specific registration is required. All YES services are billable by qualified providers in Optum's Network, assuming they have met all requirements for the respective services as described in the Level of Care Guidelines and Optum Idaho Provider Manual. If you have further questions about your ability to provide specific services, please contact your Provider Relations Advocate at optumidaho.com > Contact Us > Regional Representation Flyer. For more information regarding training opportunities, please see optumidaho.com > For Network Providers > Provider Meetings and Trainings. Please also see Provider Alerts for announcements regarding specific services at optumidaho.com > For Network Providers > Alerts & Announcements.

Q8. ***Will YES Services only be available to Medicaid clients?***

A8. The Department of Health and Welfare will ensure that services and supports are made available to all children who are determined to have serious emotional disturbance (SED), with the goal to utilize Medicaid reimbursement when the child is a Medicaid member. Children and youth who qualify for Medicaid can receive YES services based on their eligibility and benefit plan. Children and youth who are not Medicaid members, and are over 300% federal poverty guideline, can access resources available through their local Children's Mental Health (CMH) offices. These resources may be available to the child or youth even if they have private insurance. Please Click Here for additional contact information.

Q9. ***How can higher income families seek services?***

A9. To receive services in the YES Program, a person must complete the following steps:

***1)** Schedule an assessment with Liberty Healthcare Corporation at 1-877-305-3469.*

***2)** Complete the assessment. The assessment can determine that a child has a serious emotional disturbance (SED). After the assessment, Liberty Healthcare Corporation will contact the family with the results. If the family disagrees with the decision, they will need to contact Liberty Healthcare Corporation at 1-877-305-3469.*

***3)** After the child is determined to have SED, the family will apply for Medicaid. If the family applies online, and they are over traditional income limits, they will receive a denial. However, the YES Program allows families to be approved for income up to 300% of the Federal Poverty Guidelines (FPG). Click Here for additional FPG information. Self Reliance will complete this manual process and send a formal notice to the family via mail.*

***4)** Contact a Targeted Care Coordinator. Once the child has been approved for Medicaid coverage, the family will contact a Targeted Care Coordinator of their choice to create a person-centered service plan (PCSP). To find a Targeted Care Coordinator, the family can call the Optum Idaho member line, 1-855-202-0973, or refer to the list of TCCs on the website at optumidaho.com > For Network Providers > Targeted Care Coordination. The youth/family have the right to choose their own TCC.*

***5)** Find a provider. Contact the Optum Idaho Member Access & Crisis Line at 1-855-202-0973 TD/TTY: 711 or visit optumidaho.com to find a provider of behavioral health services in your area. Children and youth who do not qualify for Medicaid, or those who choose to not accept YES services, may be referred and connected to other community services like the following:*

Liberty Healthcare: 1-877-305-3469
Self Reliance: 1-877-456-1233

CMH Office: Click Here
211 Idaho Care Line: 211

Q10. ***What is being done to address workforce issues at all levels to deliver these YES services? (Revised July 2023)***

A10. Optum continues to work with Medicaid regarding their role in assisting with workforce development, and Medicaid will monitor Optum's work with the Provider Advisory Committee (PAC) to create a workforce development strategy. If you have an interest in being on this committee, please contact your Provider Relations Advocate.

Beyond these efforts, Optum has worked to develop many free training events online and throughout all regions in the state, educating providers and other community stakeholders about the YES Principles of Care and Practice Model, YES services, Youth Support, Targeted Care Coordination, Skills Building, and Respite, for example. Optum has also partnered with nationally recognized institutions such as the REACH Institute, the Crisis Prevention Institute, and the Praed Foundation to offer free certification events and in-depth training to Optum providers. Please continue to check our website, as trainings are added on an ongoing basis.

Q11. ***Will the YES program impact Katie Beckett eligibility?***

A11. No. Katie Beckett eligibility is a separate determination. A child or youth and their family will go through the YES independent assessment process using the Comprehensive Diagnostic Assessment (CDA) and CANS to determine Youth Empowerment Services Program eligibility.

Q12. ***Where can we go for additional information on the YES System of Care?***

A12. Additional information on the YES System of Care and the Jeff D. Settlement Agreement can be found online at yes.idaho.gov. Medicaid, DBH, and Optum are committed to timely communication on any upcoming changes and/or training for our providers on the YES System of Care within the State of Idaho. Provider trainings will be communicated through ongoing Provider Alerts. Questions on the YES System of Care can be submitted at optum.idaho.yes@optum.com.

Q13. ***If the member moved from traditional Medicaid to the YES Program, but they no longer want or need Respite, how do they move back to traditional Medicaid? (Revised July 2023)***

A13. Members who moved from traditional Medicaid to the YES Program for Respite services may move back to traditional Medicaid if Respite is no longer needed or wanted. In this situation, the member can call the Idaho Department of Health and Welfare's Self Reliance Program to opt out of the program which will remove them from provider lists and program reminders. The member would not need to complete a reevaluation through an independent assessment, obtain a Targeted Care Coordinator, or complete a person-centered service plan (PCSP). These members will receive notification from the Idaho Department of Health and Welfare's Self Reliance

Program when it's time for Medicaid eligibility renewal. Please follow their instructions to complete renewal of eligibility.

Q14. ***Can a member get retroactive coverage for services provided before they became eligible for YES? (Revised July 2023)***

A14. Medicaid eligibility determinations are managed by the Idaho Department of Health & Welfare (IDHW)'s Self Reliance team. To learn more about Medicaid eligibility, members may contact Self Reliance at 1-877-456-1233 or visit https://healthandwelfare.idaho.gov/contact-us. When a member gains Medicaid eligibility retroactively, Optum works with the member and provider as needed to determine coverage for services covered in the Idaho Behavioral Health Plan rendered during the time period covered by a member's retroactive eligibility. Providers may call Optum at 1-855-202-0983, Option 2, or follow the Provider Dispute or Retrospective Review process as outlined in the Provider Manual dependent upon the member's situation.

Targeted Care Coordination (TCC) / Child and Family Teams (CFT) / Person-Centered Service Planning (PCSP)*

Q15. ***How do I become a TCC?***

A15. Providers wanting more information about being a TCC in the Optum Idaho Network may speak with their Provider Relations Advocate and/or review the TCC page of the website to determine if this service is of interest.

For additional information on requirements and/or to enroll as a TCC, please visit optumidaho.com > For Network Providers > Provider Meetings & Trainings > Optum Idaho Training Opportunities > Targeted Care Coordination. The Optum Idaho Education Team will then assign the training plan to the provider in their Relias account. The assigned modules must be completed before starting TCC services or using Optum Supports and Services Manager (OSSM) to submit PCSPs to Optum.

Once training is completed, Optum will add the TCC's agency name to the approved list for member referrals. This list is updated on the Optum Idaho website on a regular basis and is also provided to members who contact Optum looking for a TCC. This process ensures that providers have completed the required training before they begin providing TCC to members and accessing their information in OSSM.

Q16. ***How do families locate a TCC? (Revised July 2023)***

A16. To find a TCC in their community, a family may either contact Optum's Member Line at 1-855-202-0973, option 1, or go to the website at optumidaho.com > For Members > Resources & Tools > Targeted Care Coordination Agencies. It is the member's and family's right and choice to select their own TCC, but Optum is here to assist them if necessary.

Q17. ***Who needs TCC and/or needs to go through the PCSP process? (Revised July***

2023)

A17. Children and adolescents that go through an independent assessment and seek Medicaid Program enrollment for income up to 300% Federal Poverty Guidelines (FPG), or members that qualify for Medicaid in traditional income limits that are seeking respite services, will need to have a person-centered service plan. A person-centered service plan, of which can be referred to as a coordinated care plan, is created in a Child and Family Team. Child and Family Teams are facilitated by Targeted Care Coordinators. Members that do not go through the independent assessment process do not need a Targeted Care Coordinator, though they are welcome to have one if they want Targeted Care Coordination.

Q18. ***If a child is enrolled in the YES program, is it mandatory that they receive TCC, even if their needs are being met with just counseling or counseling and medication management? (Revised July 2023)***

A18. All children/youth in the YES Program are required to have a person-centered service plan (PCSP) developed in a Child and Family Team. Per the Federal requirements for programs authorized under the 1915(i) State Plan Amendment, every child must have a PCSP that meets the requirements in 42 CFR 441.725.

PCSPs can be completed by Target Care Coordinators (TCC) enrolled in the Idaho Behavioral Health Plan (IBHP) provider network, Developmental Disability (DD) Case Managers (CM) with the Division of Family and Community Services, or Wraparound Coordinators or clinicians with the Division of Behavioral Health.

It is a federal requirement that members enrolled in the YES Program Complete a Person-Centered Service Plan (PCSP) within ninety (90) days of enrollment in the YES Program and update the PCSP at least annually within three hundred and sixty-four (364) days of the previous plan. The PCSP must include all services the member and their family may use during the member's treatment, including any 1915(i) services they will use (currently, the only 1915(i) service is respite).

Services may begin while the PCSP is being developed. If the child's needs are being met through counseling or counseling and medication management, then those services would be included in the PCSP as identified through the Child and Family Team. Federal requirements dictate that members must utilize a 1915(i) service (currently, the only 1915(i) service is respite) at least one (1) time per eligibility year with a Medicaid-enrolled provider. Respite must also be listed in the member's PCSP.

Please also refer to the question below to see which members should continue to work with their IDHW Case Manager instead of an Optum TCC.

Q19. ***Can families who are working with a case manager at Idaho Department of Health and Welfare's (IDHW's) Developmental Disabilities Program or Children's***

Mental Health (CMH) for Wraparound or 20-511A receive TCC and will they need a TCC to create their person-centered service plan to remain eligible for YES? (Revised July 2023)

A19. If your family is actively working with either

- *an Idaho Department of Health and Welfare (IDHW) Wraparound Coordinator through Children's Mental Health and your child has a Wraparound plan, or*
- *an IDHW case worker for a 20-511a court order and they have completed a PCSP for your child, or*
- *an IDHW Developmental Disabilities (DD) Program Case Manager and has a DD Plan of Service with a "YES Appendix",*

you do not need an additional PCSP developed by a Targeted Care Coordinator. Families have the same access to services, regardless of whether their PCSP or Plan of Service was developed by an Optum TCC or an IDHW case manager. If you are unsure if a family is working with an IDHW Case Manager, you can contact Medicaid for more information at 1-866-681-7062.

Q20. ***Can families who are working with a case manager at Idaho Department of Health and Welfare's (IDHW's) Child Protection Services (CPS) receive TCC and a PCSP? (Revised July 2023)***

A20. Families who are involved with CPS will work with a Case Manager at CPS to develop a Plan of Service. This is not the same as a PCSP. If the child/youth is also part of the YES Program, then they will need to fulfill the requirements of the YES Program to maintain their eligibility in the program.

Q21. ***Does a Child and Adolescent Needs and Strengths (CANS) or a Comprehensive Diagnostic Assessment (CDA) need to be completed prior to offering TCC?***

A21. Newly eligible YES members will have gone through the independent assessment process and therefore should have a CANS and CDA from Liberty Healthcare. There should be no need to complete another CDA or CANS right away unless the provider does not fully agree with the results. If the Liberty CDA does not meet the requirements of the provider, they need to have an intake conversation (billing either 90791 or 90834) and fill in the gaps with an addendum. The auditors will consider both the initial CDA and the addendum in their review of the treatment records. As a reminder, the CANS does need to be updated every 90 days by a CANS certified provider using the ICANS platform.

Q22. ***Who on the Child and Family Team is responsible for updating the CANS?***

A22. The CANS should be administered with child and family engagement and the members of the CFT should collaborate to identify who would be the best CANS certified provider to administer the CANS. Optum network providers that are CANS certified master's level clinicians and/or CANS certified bachelor's level paraprofessionals in a human services field who are involved in the member's care can complete and bill for the initial/annual CANS and

CANS updates. For additional information, please see the Optum Idaho Provider Manual> Child and Adolescent Needs and Strengths (CANS) section.

Q23. ***Will Optum recoup TCC paid claims if a child doesn't have an updated CANS?***

A23. No. As we build the network, we realize there may be some delays in the child receiving an updated CANS as quickly as needed. Services will not be denied, and claims will not be recouped because a child doesn't have an updated CANS.

Q24. ***Who is on the CFT?***

A24. The CFT Interdisciplinary Team Meeting is scheduled by the TCC and is a meeting with the child and their family present. The CFT meeting must also include an independently licensed clinician (or a master's level clinician under the Supervisory Protocol) who participates face-to-face or via telehealth. Other than the TCC, network providers must participate face-to-face or via telehealth, when appropriate. Additionally, a CFT will include individuals selected by the child and family who are to be involved in coordinating their care or who will provide support throughout care such as a soccer coach or neighbor. The TCC may have a conversation with a treating provider if they are unable to attend the CFT to make sure there is alignment with content in the person-centered service plan.

Q25. ***Does the Targeted Care Coordinator have to be present at the CFT Meeting for the provider to bill the service?***

A25. Yes, the Targeted Care Coordinator must schedule, attend, and facilitate the CFT meeting for it to be considered a formal, billable CFT Interdisciplinary Team Meeting.

Q26. ***I'm not getting invited to the CFT Interdisciplinary Team Meetings. How do I get an invite?***

A26. Speak with the family about participating in their Child and Family Team, but it is ultimately up to the child or youth and their family who attends. You may also contact the TCC, who can document this request in the person-centered service plan (PCSP). Even if unable to attend the CFT meeting, treatment goals should still align with the PCSP developed by the CFT.

Q27. ***Can one clinician from an agency attend all CFT meetings for all of our clients? (Revised January 2022)***

A27. No. The clinician(s) and/or paraprofessional(s) who provide services to the member and has a relationship with the child/family should be the one(s) to attend the meeting. If a child is not receiving individual or family therapy, the clinician that completed the child's Comprehensive Diagnostic Assessment must attend the CFT meeting.

Q28. ***Can a TCC get reimbursed for traveling to a family's home?***

A28. Yes. TCC providers can be reimbursed for mileage when completing TCC services in the family's home. Best practice is to only bill one time if providing TCC services to different family members during one trip. Code T2002 is used for transportation and mileage reimbursement.

Q29. ***Does the entire family need to be present for the CFT meeting?***

A29. At least one parent or legal guardian must be present for the CFT meeting, and it's highly recommended that the child attends as well, to ensure he/she agrees with the PCSP. However, we understand there may be circumstances, such as illness or hospitalization, which may not allow the child to be present. If this is the case, the reason for the child's absence must be documented in the PCSP.

Q30. ***Can a child receive services from an agency where they also receive TCC?***

A30. Until further notice, a TCC's supervising clinician (established by Supervisory Protocol) can deliver direct services to a child (if there are no other options available to the child) and may still supervise the TCC. As a reminder, it is best practice to separate direct supervision of another professional who is also providing services to the same child as the supervising clinician. Optum continues to work with the Division of Medicaid to develop a strategy to meet conflict-free requirements per CFR 441.301.c.vi. However, the requirement that TCCs are not to provide other services to the child remains in effect.

Q31. ***Can a CFT meeting be facilitated via telehealth?***

A31. Yes, a CFT can be facilitated via telehealth. For more information about telehealth, consult the Provider Manual.

Q32. ***What is a PCSP? (Revised July 2023)***

A32. A PCSP is a type of a coordinated care plan where the person is supported to use their own power to choose what they will do and who will help them to achieve a life meaningful to them. The PCSP incorporates the results of the Comprehensive Diagnostic Assessment (CDA) and CANS functional assessment and is a result of Child and Family Team (CFT) Interdisciplinary Team Meetings. In the Medicaid YES Program, this process is directed by the child/family, is ongoing, and focuses on the strengths, interests, and needs of the whole person. PCSPs include the child's overall treatment goals and objectives, strengths, needs, crisis/safety plan, and a transition plan.

PCSPs can be completed by Target Care Coordinators (TCC) enrolled in the Idaho Behavioral Health Plan (IBHP) provider network, Developmental Disability (DD) Case Managers (CM) with the Division of Family and Community Services, or Wraparound Coordinators or clinicians with the Division of Behavioral Health. For YES Program-eligible members, the PCSP must include all services the member and their family may use during the member's treatment, including any 1915(i) services they will use (currently, the only 1915(i) service is respite).

Q33. ***Who creates the PCSP?***

A33. The PCSP is a collaborative effort by all members of the Child and Family Team (CFT). An Optum Targeted Care Coordinator (TCC) enrolled in the Optum network facilitates the formal CFT meetings and creates and finalizes the plan with input from the team.

If the child has gone through the Independent Assessment and is not completing a plan with a Department Case Manager, Optum must review the finalized PCSP to ensure adherence to the Code of Federal Regulations. However, if the child is a part of the Developmental Disability program, 20-511A, or Wraparound program, the coordinated care plan will be developed as a part of those meetings and are acceptable to meet the requirements for the YES Program.

Q34. ***How often does a PCSP need to be updated? (Revised July 2023)***

A34. It is a federal requirement that members enrolled in the Medicaid YES Program complete a Person-Centered Service Plan (PCSP) within ninety (90) days of enrollment in the YES Program and update the PCSP at least annually within three hundred and sixty-four (364) days of the previous plan. PCSPs may be updated more frequently if the child/family requests it or whenever clinically indicated, such as by changes in the CANS.

Q35. ***Will a child lose eligibility if they don't get their PCSP updated in a timely manner? (Revised July 2023)***

A35. If a member's PCSP is not updated annually, they will not be able to continue eligibility for the YES Program. It is a federal requirement that members enrolled in the Medicaid YES Program have a person-centered service plan developed within 90 days of becoming eligible and update their PCSP within 364 days of the initial PCSP.

Q36. ***May the child receive services while waiting for the PCSP to be developed? (Revised July 2023)***

A36. As soon as a child is approved for the YES Program and becomes approved for Medicaid, all Medicaid billable services can be accessed. The child may receive medically necessary services while the PCSP is in development, but these services should be documented on the PCSP along with the names of the providers who are participating. We urge you to help connect your YES members with TCCs in your agency or community to develop a PCSP which includes recommended services. Medicaid will soon be enforcing the TCC/PCSP requirement.

As a reminder, children accessing services through the 1915(i) State Plan Amendment (expanded income or traditional Medicaid needing Respite) are required to have their PCSP updated at least annually within three hundred and sixty-four (364) days of the previous plan and must utilize a 1915(i) service (currently, the only 1915(i) service is respite) at least one (1) time per eligibility year with a Medicaid-enrolled provider. Respite must also be listed in the member's PCSP.

Q37. ***How do we ensure collaboration on treatment goals and services within the CFT?***

A37. One of the key parts of the PCSP is a formalized and agreed upon consensus building process for the CFT to identify the goals of the child and family. Through that process, the child and family will lead the team as the team collaborates to determine appropriate services and treatment for the child/family. The TCC will have the responsibility to ensure that there is collaboration and agreement for the services that will be documented on the PCSP through their facilitation and support of the child and family. The CFT also develops conflict resolution guidelines, which are also included in the PCSP, to help the teamwork through disagreements that may arise during the planning process.

Q38. ***Who needs to sign the PCSP? (Revised January 2022)***

A38. All CFT members need to sign the PCSP, including the parent(s) or legal guardian(s), the child (if the family thinks the child is age-appropriate to sign) and the TCC. This also includes all providers from behavioral health, mental health, developmental disabilities and substance use who are treating the child, as well as informal supports or anyone else in attendance. If the provider is listed on the PCSP, even if they did not attend the CFT meeting, they must sign the PCSP (or provide an email to the TCC stating they agree to work on the goals identified in the PCSP and render the service(s) to the member). For clarification, if a child is receiving direct services from any providers, they must be listed on the PCSP and agree/sign. The TCC's signature attests that the TCC has these appropriate signatures on file.

For providers that are not within the Optum Network, or if the provider refuses to participate, their service will not be included in the plan. The PCSP can still be approved through Optum, and the TCC should work with the family to get the providers to engage. All efforts should be made to obtain agreement and signature, though this lack of participation should not create a barrier to care for the child. Any/all attempts made to retrieve agreement/signature should be documented. An example of this type of provider would be any medical provider or, if an Optum Network provider refuses to participate in the CFT, they would not be providing direct services to the child.

Q39. ***How do CFT members sign the PCSP? (Revised January 2022)***

A39. The TCC is responsible for obtaining agreement for the PCSP from the participating providers and other CFT members. The TCC's electronic signature on the PCSP means that the TCC has either emails and/or signatures on file from CFT members, subject to audit. The provider signature confirms agreement to work on the goals identified in the PCSP in the specific service(s) recommended within the PCSP and intention to render the service to the member.

Q40. ***Where is the blank PCSP form? How do I send the PCSP to Optum?***

A40. Please refer to optumidaho.com > For Network Providers > Targeted Care Coordination. The blank PCSP form is located on the website in both English and Spanish. Please save it to your desktop before using and make sure you are using Adobe Acrobat Reader DC, which can be downloaded for free from

Adobe's website.

This webpage is also where you can log in to Optum Supports and Services Manager (OSSM), under the TCC section, in order to submit the completed PCSP to Optum for review of compliance under the Code of Federal Regulations (CFR). Please refer to the OSSM Instruction Manual located on the same page.

Q41. ***What if I'm having problems logging in to Optum Supports and Services Manager (OSSM)?***

A41. After you have completed the TCC training, you should receive an email from OSSM Provisioning. Be sure to follow the email instructions when logging in for the first time. If you are still having difficulties, please email us at optum.idaho.pcsp@optum.com or call us at 1-855-202-0983, option 1. Please provide your first and last name, email, phone number, and Optum ID (if you have one).

Q42. ***Does the TCC document their progress notes on Optum Supports and Services Manager (OSSM) or do they continue to document those through their agency?***

A42. For YES 1915(i) State Plan Amendment children, progress notes may be documented in OSSM if you like, but you should primarily store progress notes in whichever platform your agency chooses to use to meet record auditing requirements. However, the attendance log must be completed in OSSM to indicate who attended the CFT meeting.

Q43. ***If TCC is accessed through traditional Medicaid, does the PCSP need to be uploaded to Optum Supports and Services Manager (OSSM)?***

A43. No. The PCSP should still be developed. However, it does not need to be submitted to Optum for CFR review. If the child is accessing services and is working with a Department Case Manager through other Medicaid programs (such as 20-511A, Wraparound, or Developmental Disabilities), you will not use OSSM to store any records.

Q44. ***How do I know if the PCSP meets the Code of Federal Regulations (CFR)?***

A44. Optum will respond to a PCSP submitted in OSSM within 5 business days. Please refer to the OSSM Instruction Manual located at optumidaho.com > For Network Providers > Targeted Care Coordination. You may also click on the plan in OSSM, and then click "Assessments" to review the CFR Review Sheet with any comments from Optum.

Q45. ***How do I update a PCSP that didn't meet CFR?***

A45. For resubmission of PCSPs not meeting CFR, please refer to the OSSM Instruction Manual located on the website at optumidaho.com > For Network Providers > Targeted Care Coordination. When changes are made to the PCSP to ensure it meets CFR, please document those conversations in the PCSP, and be sure the TCC signs it with the Revised date.

Q46. ***Can the TCC provide other services to the member?***

A46. No. TCCs cannot provide other direct services to the child.

Q47. ***Can a treating provider bill for attending a CFT meeting facilitated by Idaho Department of Health and Welfare (IDHW) for a child that is part of the Developmental Disabilities, Wraparound, or 20-511A programs?***

A47. Yes. Optum Idaho Network Providers may bill for attending a CFT meeting using G9007, regardless of whether it's facilitated by the Optum TCC or IDHW case manager, as it is important for the providers to engage in all of the care for the child or youth.

1915(i) Independent Assessment

Q48. ***Why are children and youth required to go through an independent assessment? (Revised July 2023)***

A48. The independent assessment process is an annual Federal requirement related to the 1915(i) State Plan Amendment. The Centers for Medicare and Medicaid services (CMS) has the ability to impose and require certain criteria in order to receive services provided through a 1915(i) State Plan Amendment. Idaho's 1915(i) allows the state flexibility to serve families with a household income of 186% to 300% Federal Poverty Guideline (FPG) for their child with serious emotional disturbance (SED), and to provide additional Medicaid-paid services to children/youth eligible under the state plan amendment.

Q49. ***Do all of my children and youth clients with SED need to go through an independent assessment? (Revised July 2023)***

A49. Children and youth's participation in the independent assessment is optional. A child may benefit from an independent assessment if the following is true:
1) *The child/youth is not Medicaid eligible under traditional income limits and is seeking eligibility through the higher limits provided by the 1915(i) State Plan Amendment (Medicaid YES Program) and;*
2) *The child/youth needs access to Medicaid-paid Respite.*

-OR-

The child/youth is Medicaid eligible under traditional income limits and needs access to Medicaid-paid Respite.

If the child/youth is Medicaid eligible under traditional income limits and does not require Respite, they do not need to go through the independent assessment, even if they have SED.

Q50. ***How often do children and youth have to complete an independent assessment? (Revised July 2023)***

A50. Children and youth will need to complete the independent assessment on a yearly basis. Liberty Healthcare will contact the family about 90 days before their assessment is due. If the child/youth gained Medicaid eligibility at a higher income (of 186%-300% FPG), they may also need to complete their redetermination through Self Reliance around the same time.

Q51. *Is the independent assessment process similar to the Developmental Disability (DD) program assessment process?*

A51. Liberty Healthcare conducts the independent assessments for both the YES Program and Developmental Disabilities (DD) 1915(i) support services. There are some similarities between the two processes; however, separate assessments are required for each program and families will apply for each separately. For more information, please contact Liberty Healthcare at 1-877-305-3469.

Q52. *If Liberty Healthcare provides a Comprehensive Diagnostic Assessment (CDA) for the member, should my agency still complete our own CDA?*

A52. You can use a CDA from any provider, including Liberty Healthcare, if it was completed within the last 6 months. The clinician is still required to do an independent clinical assessment/interview to verify that the information provided hasn't changed.

Q53. *What do I do if the CDA from Liberty Healthcare is incomplete or I don't agree with it?*

A53. If the Liberty CDA does not meet the requirements of the provider, they need to have an intake conversation (billing either 90791 or 90834) and fill in the gaps with an addendum. The auditors will consider both the initial CDA and the addendum in their review of the treatment records.

Q54. *Can Liberty Healthcare accept a Child and Adolescent Needs and Strengths (CANS) assessment and CDA that were completed by an Optum network provider?*

A54. Yes, Liberty Healthcare can accept a CANS that has been completed within the last 100 days. Liberty can use a CDA that was completed in the last 6 months. The assessor is still required to do an independent clinical assessment/interview to verify the information provided hasn't changed. The assessor will then complete a CANS update in ICANS to document any changes.

Q55. *How do I contact Liberty Healthcare?*

A55. Liberty Healthcare can be reached by phone at 1-877-305-3469 or by email at idahoyes@LibertyHealth.com.

Q56. *What if I have additional questions or concerns about Liberty Healthcare and/or their CDA?*

A56. For any questions or concerns about Liberty Healthcare, you can email Medicaid

at YESLiberty@dhw.idaho.gov.

Child and Adolescent Needs and Strengths (CANS)*

Q57. ***Who can conduct the CANS?***

A57. Optum network providers who are independently licensed clinicians (or master's level clinicians working under supervisory protocol) who are certified in the CANS can bill for the initial/annual CANS (if one has not yet been completed) and CANS updates. A CANS certified bachelor's level paraprofessional in a human services field can complete CANS assessments (initial/annual and updates) if they are involved in the member's care. In some cases, a bachelor's level paraprofessional may need to refer some more difficult applications to a CANS certified master's level clinician. If a CANS is completed by a bachelor's level provider, an Independent Assessor or the treating clinician will need to conduct the CDA.

Q58. ***Why is the CANS required vs other assessment tools?***

A58. The CANS was identified in the Jeff D. Settlement Agreement as the functional assessment tool to be used in the State of Idaho. The CANS is currently used in all 50 states and helps ensure a solid foundation for treatment planning as well as an ongoing method for measuring clinical outcomes.

Q59. ***Where can I find more information on the CANS?***

A59. Additional information on the CANS can be found on the Praed Foundation website at Praedfoundation.org

Q60. ***How long does it take to complete a CANS?***

A60. The time to complete a CANS assessment will vary depending on factors such as the child's/youth's and family's presentation, current risk factors, and complexity of the strengths and needs of the child's/youth's and family, and the provider's experience in administering the CANS.

Q61. ***What is the cost to become CANS certified?***

A61. The cost to complete the CANS certification online is $12.00 annually. Additional information on the CANS can be found on the Praed Foundation website at Praedfoundation.org. Individuals should allow approximately 8 hours of uninterrupted time to complete the certification.

Q62. ***What training opportunities are in place for the CANS?***

A62. The Division of Behavioral Health (DBH) launched the CANS Training Network to train practitioners in the practical application of the principles of Idaho Transformational Collaborative Outcomes Management (TCOM) Institute, as

well as the administration of CANS in treatment planning and staff supervision.

*As of Nov. 1, 2020, providers must attend a live training session offered by DBH in order to become certified to administer the CANS. These training sessions will be offered throughout the month to ensure adequate access. Individuals who have already been certified on the CANS **do not need** to take the live training and may access the recertification exam via the Praedfoundation.org platform. However, any individual who wishes to participate in the live training may choose to do so.*

Providers can register for CANS training through the Idaho TCOM Institute website by clicking here.

For additional information, please see the related provider alert "TCOM Provider Update" from Oct. 15, 2020 or email the Dept. of Health and Welfare at ITI@dhw.idaho.gov.

Q63. ***How do I add my agency to the CANS training on the Praed website?***

A63. Please email Praed at support@tcomtraining.com with your agency name to have your agency added to the drop-down listing of Idaho providers. For more information about the Praed foundation and their website, please reach out to support@tcomtraining.com.

Q64. ***Do I need to complete a CANS if my client is not a Youth Empowerment Services Program Member?***

A64. Yes. As of July 1, 2019, the CANS is the state-required functional assessment tool for all children and adolescents who receive services through the Idaho Behavioral Health Plan. Services that do not require a CANS are Neuro/Psych Testing, Medication Management, and Crisis Services.

Q65. ***Where do I complete the CANS?***

A65. The CANS assessment is administered through an online platform called ICANS that is hosted by the Division of Behavioral Health (DBH). For more information about ICANS, please reach out to DBH at icanshelpdesk@dhw.idaho.gov or visit their website at icans.dhw.idaho.gov.

Q66. ***How do I get set up with ICANS?***

*A66. To get set up on the ICANS platform, providers are required to sign and submit an Agency Agreement, Authorized User Agreement for each staff, and attend ICANS System training. For more information, please navigate to icans.dhw.idaho.gov for the **Calendar** of trainings and **Resources and User Guide** tabs for all system requirements, electronic system manual, and additional information. For help with this process, contact the Automation Help Desk, at the Division of Behavioral Health, at (208) 332-7316 or submit a ticket via email at icanshelpdesk@dhw.idaho.gov.*

Q67. ***Does the CANS replace the CDA?***

A67. No. Both the CDA and CANS are required for children and adolescents receiving services under Medicaid.

Q68. ***Are both the CANS and CDA reimbursable?***

A68. Yes. The CDA is used to form a mental health diagnosis, and the CANS determines functional impairment and is used in treatment planning. Both can be done on the same day. The CANS must be completed within the ICANS platform for a provider to bill and be reimbursed for the CANS. The initial or annual updated CANS can be completed in conjunction with an initial or updated Comprehensive Diagnostic Assessment (CDA), by the Independent Assessor or the treating clinician. If the CANS is completed by a bachelor's level provider, an Independent Assessor or the treating clinician will need to conduct the CDA.

Q69. ***How often does the CANS need to be updated?***

A69. The CANS will need to be updated at a minimum of every 90 days, when it's requested by the individual, or when there is a substantial change to the child or youth that would indicate the need for re-assessment. The CANS may be updated by the Targeted Care Coordinator who is working with the member, by a master's level clinician, or by a CANS certified bachelor's level paraprofessional in a human services field if they are involved in the member's care.

Q70. ***Do independently licensed clinicians providing individual psychotherapy need to be CANS certified?***

A70. We encourage all network providers to become CANS certified and set up on the ICANS platform. Effective July 1, 2019, the CANS is the state-required functional assessment tool for all children and adolescents.

Q71. ***Can a network provider complete the initial CANS assessment?***

A71. Yes. If the child or youth is not going through the Independent Assessor (Liberty Healthcare), the network provider will administer the initial CANS and the subsequent (90-day) updates.

Q72. ***What CANS outcomes are measured and do providers have access to statewide data?***

A72. The CANS can be used to monitor outcomes. This can be accomplished in two ways. First, items that are initially rated a '2' or '3' are monitored over time to determine the percent of youth who move to a rating of '0' or '1' (resolved need, built strength). Secondly, dimension scores can also be generated by summing items within each of the dimensions (Problems, Risk Behaviors, Functioning, etc.). These scores can be compared over the course of treatment. CANS dimension scores have been shown to be valid outcome measures in behavioral health treatment.

To ensure providers have the most appropriate data measurements possible, the ICANS system provides each agency access to their own

Transformational Collaborative Outcomes Management (TCOM) data via the reports section on the home dashboard. The Department of Health and Welfare gathers statewide CANS data to perform comparisons and measure trends. This information is used to assist with workforce development and ensure members access to care.

Q73. ***Can the Child and Adolescent Functional Scale (CAFAS) continue to be used? (Revised July 2023)***

A73. The CANS is the state-required functional assessment for all Medicaid members under the age of 18. However, Optum does not mandate what additional assessments are appropriate for use. Rather, it's based on clinical discretion, as long as the CANS is used initially and updated every 90 days.

Q74. ***Can code H0031 (CANS) be billed for all members or just YES members?***

A74. The H0031 code can be billed for all children and adolescents receiving a CANS assessment from a CANS certified professional, completed on the ICANS platform. The CANS can be billed with H0031 with a modifier HN (for bachelor's level), HO (for master's level), or U1 (for prescribers) in group agencies billing under the Supervisory Protocol.

Q75. ***Who can administer the CANS and determine SED?***

A75. In order to access 1915(i) State Plan Amendment services (e.g., Respite), the initial and annual assessment must be done by the Independent Assessor, Liberty Healthcare. This is a federal requirement of the state plan amendment. To schedule an independent assessment, please call Liberty Healthcare at 1-877-305-3469.

Q76. ***What if I'm having trouble with the ICANS platform?***

A76. Please click here for ICANS assistance.

Q77. ***Can I administer the CANS in the child's home?***

A77. Both CANS certified master's level clinicians and CANS certified bachelor's level paraprofessionals can be reimbursed for mileage when completing the CANS assessment whether initial, update or annual, in the child or adolescent's home. Best practice is to only claim the mileage code one time if providing multiple CANS assessments to different family members during one trip. The transportation and mileage reimbursement code is T2002.

Skills Building*

Q78. ***Who is required to be present at a Skills Building treatment planning session? Do team members need to be physically present? (Revised July 2023)***

A78. Treatment planning for the provision of Skills Building should be completed with the member's clinician, the Skills Building paraprofessional, the member &

their family or other natural support present. The telehealth portion of the provider manual does apply to this billing code. For more information about telehealth, please refer to the Provider Manual.

Q79. ***Can the clinician and paraprofessional both bill for Skills Building/CBRS treatment planning on the same day?***

A79. Yes, both providers may bill for Skills Building/CBRS service-specific treatment planning (H0032) on the same day working with the member present. In order to bill for Skills Building/CBRS, the clinician and paraprofessional must develop the treatment plan using the teaming approach and both can bill for their time. Please refer to the Provider Manual and the Level of Care Guidelines for more information.

Q80. ***How is the CANS incorporated into Skills Building?***

A80. Providers are required to utilize the CANS to identify the member specific functional strengths and needs to be addressed with Skills Building/CBRS. Providers will use the CANS results/measurements to develop the Skills Building treatment plan in order to demonstrate treatment progress or to substantiate the need to modify treatment plans.

Skills Building/CBRS treatment plans should include attainable, measurable objectives aimed at assisting the member in achieving his/her goals related to the specific functional need. Goals for Skills Building/CBRS focus on resolution of functional impairments which will be reflected as CANS scores improve. When CANS scores do not improve, the interventions should be assessed and changes to treatment considered. For more information, consult the Provider Manual.

Respite

Q81. ***What is respite?***

A81. Respite is in-person, short-term or temporary care for children and youth with serious emotional disturbance (SED) provided in the least restrictive environment that provides relief for the usual caretaker and that is aimed at de-escalation of stressful situations. Individual respite is provided by a credentialed agency in the member's home, another family's home, foster family home, a community-based setting and/or at the agency facility. Group respite may only be provided at the credentialed agency facility, a community-based setting, or in the home for families with multiple children who have been determined to have SED. Respite services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment care needs. The duration of individual respite care varies and may include an overnight stay in the member's home, as identified by the Child and Family Team (CFT)

but will not exceed a single episode of 72 hours.

Q82. ***What are the credentials and qualifications for those providing respite care?***

A82. A respite provider must be a minimum of 18 years of age, have at least a high school diploma or GED, and must complete the 10-hour "Respite Care for Families of Youth with Serious Emotional Disturbance" course on Relias.

Q83. ***Is there training for respite supervisors?***

A83. Yes, there is a one-hour training module on Relias designed specifically for supervisors of respite workers titled "Respite Care for Families of Youth with SED Supervisor Training".

Q84. ***Does respite need to be prior authorized? (Revised July 2023)***

A84. No, respite does not require prior authorization, but must be included on the person-centered service plan (PCSP) for all members in the YES Program. The total annual limit for respite (group and individual combined) for a member is 300 hours per calendar year.

Q85. ***What are the guidelines for providing respite in a group setting?***

A85. Group respite may be provided at the credentialed agency facility, in the community setting or in the home for families with multiple Medicaid eligible SED children. Group respite services shall be provided at a staff-to-participant maximum ratio of 1:4. Group respite does not allow for an overnight stay. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff-to-participant ratio must be adjusted accordingly. As a reminder, respite services are provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental, and treatment care needs.

Q86. ***Can children and youth receive respite care from an Optum network provider and a Developmental Disabilities (DD) Program provider?***

A86. If a member is eligible for respite through both waivers, they may receive respite through an Optum network provider and through a DD provider. Respite delivered through each program will have to follow and comply with each program's requirements. For example, YES members will need to have a PCSP that includes respite as a service, have a hard limit of 300 hours per calendar year, etc.

Q87. ***Can children and youth receive respite care if their person-centered service plan (PCSP) is not completed?***

A87. Children and youth who go through the Liberty Healthcare independent assessment process, and have been determined to have SED, may access respite services immediately. However, once a child/youth has an approved person-centered service plan, respite must be included on it.

Q88. ***NEW QUESTION: Do YES Program members have to receive respite? (ADDED July 2023)***

A88. For Medicaid participants to maintain enrollment in the YES Program, they must utilize a 1915(i) service (currently, the only 1915(i) service is respite) at least one (1) time per eligibility year with a Medicaid-enrolled provider. Respite must also be listed in the member's PCSP.

Miscellaneous

Q89. ***What do the hourly guidelines for the services mean on the fee schedule?***

A89. The number of units indicated for some of the YES services are a guideline for providers. Providers should make a clinical decision and be guided by medical necessity while being aware of the utilization guideline. The provider is not responsible for units used outside of their agency. Except for Respite, which has a hard cap of 300 hours per year, there is not a hard cap in place to automatically deny claims that exceed the guideline(s) at this time. Optum monitors utilization by reviewing outliers and requesting records on cases that exceed the hourly guidelines to understand the needs of the member.

Q90. ***Can a multi-family group be separated into children/youth and parents and receive psychoeducation separately with each group? If so, can two providers be present at each group?***

A90. Yes. If a provider is following an evidence-based practice for Family Psychoeducation that recommends the parents and children/youth are separated for a group. It is recommended that providers use SAMHSA's Family Psychoeducation Evidence-Based Practices (EBP) Kit. As noted in the Provider Manual, Multifamily Group Psychoeducation (2-5 families) warrants two providers, at least one being an independently licensed clinician or an individual with a master's degree who is able to provide psychotherapy in a group agency under Optum's Supervisory Protocol. The second may be a minimum of a bachelor's level paraprofessional operating in a group agency under Optum's Supervisory Protocol. More than one provider can be present at each group, although no more than two providers may bill for facilitating a Multiple Family Group Psychoeducation session.

Q91. ***What is a paraprofessional registry?***

A91. The paraprofessional roster is an online database that allows providers to register the basic information of their non-licensed workforce with Optum. As a recommendation, any clinical staff (LSWs, CADCs, Skills Building paraprofessionals) working with Medicaid members under Optum's Supervisory Protocol should be recorded on this registry. The registry is located at providerexpress.com > Our Network > State-Specific Provider Information > Idaho > Paraprofessional Registry.