Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 22-0014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

September 28, 2022

Juliet Charron
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 8320
Boise, ID 83720-0009

Re: Idaho State Plan Amendment (SPA) 22-0014

Dear Ms. Charron:

This letter is in regard to the State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0014. This SPA seeks to expand passive enrollment of the Medicare-Medicaid Coordinated Alternative Benefit Plan to three additional counties where there is only one participating health plan.

Please be informed that this SPA was deemed approved on June 13, 2022, pursuant to regulations at 42 CFR § 430.16, with an effective date of April 1, 2022. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Courtenay Savage at 312-353-3721 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Charles Beal

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

September 28, 2022

Juliet Charron
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 8320
Boise, ID 83720-0009

Dear Ms. Charron:

This letter accompanies the deemed approval of state plan amendment (SPA) ID-22-0014.

To ensure that the language approved in ID-22-0014 is not superseded in the state plan with the approval of ID-20-0006, which is pending the state's response to a Request for Additional Information (RAI), please include the approved SPA language from ID-22-0014 in the ID-20-0006 RAI response. The ID-20-0006 RAI response must also include the effective date of April 1, 2022 next to the language changes that were approved in ID-22-0014.

If you have any questions, please contact Courtenay Savage at 312-353-3721 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

cc: Charles Beal

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Idaho**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

ID 22-0014

Proposed Effective Date

04/01/2022 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR § 411.163

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2022	$ 3209907.46
Second Year	2023	$ 6364609.69

Subject of Amendment

Geographical Area Expansion of MMCP SPA.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ◉ **No reply received within 45 days of submittal**
- ○ **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:	**Charles Beal**
Last Revision Date:	**Mar 14, 2022**
Submit Date:	**Mar 14, 2022**

7/28/22: State approved pen and ink change to templates ABP2b, ABP4, ABP7, ABP8, ABP9, and ABP10 in order to change the TN header from 21-0014 to 22-0014.

Alternative Benefit Plan

State Name: Idaho Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: ID - 22 - 0014

Alternative Benefit Plan Populations ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Medicare-Medicaid Coordinated Alternative Benefit Plan

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	SSI Beneficiaries	Voluntary	Remove
Add	Disabled Adult Children	Voluntary	Remove
Add	Parents and Other Caretaker Relatives	Voluntary	Remove
Add	Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	Voluntary	Remove
Add	Individuals Receiving Mandatory State Supplements	Voluntary	Remove

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

- ☐ Income Standard.
- ☐ Disease/Condition/Diagnosis/Disorder.
- ☒ Other.

Other Targeting Criteria (Describe):

Enrollment in this MMCP ABP is only available for participants who are fully eligible for Medicare Part A and Part B and who are eligible for the Medicaid Basic or Enhanced Plan.

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. No

Select a method of geographic variation:

- ◉ By county.
- ○ By region.
- ○ By city or town.
- ○ Other geographic area.

Specify counties:

The MMCP ABP is available in the following 33 of 44 Idaho counties: Ada, Adams, Bannock, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Clark, Clearwater, Elmore, Fremont, Gem, Gooding, Jefferson, Jerome, Kootenai, Latah, Lincoln, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Shoshone, Twin Falls, Valley, and Washington.

Any other information the state/territory wishes to provide about the population (optional)

Idaho Medicaid currently operates both the Medicare Medicaid Coordinated Plan (MMCP) and Idaho Medicaid Plus (IMPlus) under two (2) health plans and requires mandatory enrollment in IMPlus once a member has enrolled in the MMCP ABP for dual-eligible participants in the following twenty-one (21) counties: Ada, Bannock, Bingham, Boise, Bonneville, Bonner, Boundary, Canyon, Cassia, Elmore, Freemont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, and Twin Falls.

Idaho Medicaid currently offers the MMCP as a voluntary program with one (1) participating health plan in these nine (9) counties: Adams, Benewah, Clark, Gooding, Jerome, Latah, Shoshone, Valley, and Washington.

Idaho Medicaid currently offers IMPlus in the following counties, with only one (1) health plan. These nine (9) counties will remain voluntary, with passive enrollment processes as described in ABP2b: Adams, Benewah, Clark, Gooding, Jerome, Latah, Shoshone, Valley, and Washington.

Idaho Medicaid submits this amendment requesting authority to expand the MMCP ABP to the following counties:

- Effective April 1, 2022, Idaho Medicaid will begin offering the MMCP ABP in the following counties, with only one (1) health plan. These three (3) counties will remain voluntary, with passive enrollment processes as described in ABP2b: Blaine, Clearwater, and Lincoln.

PRA Disclosure Statement

V.20181119

Alternative Benefit Plan

State Name: Idaho Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: ID - 22 - 0014

Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2b

These assurances must be made by the state/territory if the ABP Population includes any eligibility groups other than or in addition to the Adult eligibility group.

When offering voluntary enrollment in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent), prior to enrollment:

☑ The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.

☑ The state/territory assures it will effectively inform individuals who voluntary enroll of the following:

a) Enrollment is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/territory plan coverage;

c) What the process is for disenrolling.

☑ The state/territory assures it will inform the individual of:

a) The benefits available under the Alternative Benefit Plan; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

How will the state/territory inform individuals about voluntary enrollment? (Check all that apply.)

☒ Letter

☐ Email

☐ Other:

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about voluntary enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Idaho Medicaid has different letters for participants enrolled in the MMCP ABP to notify them of their eligibility to enroll in either the Medicaid Coordinated Plan (MMCP) and/or the Idaho Medicaid Plus (IMPlus) plan.

Voluntary Enrollment Counties
~ When the voluntary MCO, the Medicare Medicaid Coordinated Plan (MMCP) becomes available in a new county or when the state identifies a newly eligible participant in in an MMCP county, Idaho Medicaid sends a letter to notify these participants of their eligibility to enroll with an MMCP health plan. This letter provides information on how to enroll in the MMCP and contact information for any questions.

Passive Enrollments in Voluntary Enrollment Counties
~ When the state identifies a newly eligible participant residing in a county with only one (1) participating health plan (Blue Cross of Idaho), Idaho Medicaid sends a letter to provide notification that they will be enrolled in an IMPlus health plan in 90 days. These letters

explain that they may opt out of IMPlus by contacting the Duals Beneficiary Support Specialist line at 1 (833) 814-8568 or by returning the enrollment form included with their letter. These participants have 90 days to opt out of IMPlus and either enroll in MMCP or remain on fee-for-service Medicaid.

Currently, there are nine (9) passive enrollment counties: Adams, Benewah, Clark, Gooding, Jerome, Latah, Shoshone, Valley, and Washington. Effective April 1, 2022, the MMCP SPA will expand into three (3) additional counties with passive enrollment: Blaine, Lincoln, and Clearwater. Idaho Medicaid mailed notification letters to eligible participants in in these counties on January 1, 2022.

Idaho Medicaid provides information and updates related to MMCP and IMPlus for dual eligible participants and other stakeholders on the public Medicaid/Medicare Participants website (https://healthandwelfare.idaho.gov/services-programs/medicaid-health/medicaidmedicare-participants).

Please describe the state/territory's process for allowing voluntarily enrolled individuals to disenroll.

Individuals enrolled in the MMCP can disenroll by contacting their Health Plan directly or by contacting the Department's Duals Beneficiary Support Specialist line at (833) 814-8568.

Individuals enrolled in the IMPlus program can disenroll by contacting the Department's Duals Beneficiary Specialist line at (833) 814-8568.

Individuals residing in passive enrollment counties have at least 90 days prior to enrollment to decline by returning the enrollment form included with their notification letter. Individuals in these counties who do not opt out within the 90-day period preceding the indicated date of enrollment may disenroll at any time by contacting the Department's Duals Beneficiary Support Specialist line at (833) 814-8568.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

Where will the information be documented? (Check all that apply.)

☐ In the eligibility system.

☐ In the hard copy of the case record.

☒ Other:

Describe:

This information is documented in the exempt individual's record within the MMIS.

What documentation will be maintained in the eligibility file? (Check all that apply.)

☐ Copy of correspondence sent to the individual.

☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other:

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in an Alternative Benefit Plan and the total number who have disenrolled.

Other Information Related to Enrollment Assurance for Voluntary Participants (optional):

Participants voluntarily enrolled in the MMCP or enrolled in IMPlus in a passive enrollment county may enroll in or disenroll from their plan at any time. Voluntary participants who disenroll retain Medicaid coverage under the fee-for-service model.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Idaho

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ID - 22 - 0014

Alternative Benefit Plan Cost-Sharing — ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Idaho | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: ID - 22 - 0014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. No

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

Alternative Benefit Plan

☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20160722

Alternative Benefit Plan

State Name: Idaho Attachment 3.1-L- OMB Control Number: 0938-1148

Transmittal Number: ID - 20 - 0006

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [ ] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [ ] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

This managed care program was authorized under 1937 authority. The 2014 Affordable Care Act replaces in whole the previously authorized program under the 2005 Deficit Reduction Act authority. The MCO agreement replaced the previously established PAHP agreement for the Idaho Medicare-Medicaid Coordinated Plan (MMCP) effective July 1, 2014. Idaho Medicaid continues to conduct ongoing web-based seminars to engage stakeholders in the development and implementation of changes to the MMCP and the ongoing implementation of the new managed care program for duals called "Idaho Medicaid Plus" (IMPlus).

Idaho Medicaid hosted over thirty town hall-style meetings for duals statewide in May 2018 to share information and solicit input on the development and implementation of IMPlus, a mandatory managed care program for duals who have not voluntarily enrolled in the MMCP and who reside in a county where there are two (2) or more participating health plans. In 2018, Idaho Medicaid initiated implementation of IMPlus. Idaho Medicaid continues to maintain regular outreach activities by facilitating ongoing engagement to educate stakeholders and solicit input via webinars, website postings, public meetings, and member and provider notifications with an enhanced focus in counties that are on-boarding participants in the newly mandatory IMPlus plan, leading up to and through the month of implementation in any new county.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

Alternative Benefit Plan

- ○ Section 1915(a) voluntary managed care program.
- ◉ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: 10/24/2018

Describe program below:

Both the Medicare Medicaid Coordinated Plan (MMCP) and Idaho Medicaid Plus (IMPlus) are designed as Medicaid Long Term Services and Supports (MLTSS) managed care delivery systems administering Medicaid benefits for full dual eligible members. Ongoing implementation activities will continue using a phased-in approach: counties will be implemented in succession contingent upon successful implementation in prior geographic areas.

Certain populations are excluded, including Medicaid participants on the Adults with Developmental Disabilities 1915(c) waiver program and pregnant women. Tribal members may elect to voluntarily enroll in the program but retain the right to disenroll at any time. Participants in these excluded populations continue to receive Medicaid benefits under the fee-for-service model.

Voluntary Enrollment:
~ The MMCP is a voluntary managed care program for Medicaid participants that are dually eligible for Medicare Parts A and B and full Medicaid ("full dual eligible"). The MMCP operates under a 1915(c) authority. MMCP is now available in the following thirty (30) counties: Ada, Adams, Bannock, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Clark, Elmore, Fremont, Gem, Gooding, Jefferson, Jerome, Kootenai, Latah, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Shoshone, Twin Falls, Washington, and Valley. In 2022, voluntary enrollment will expand to an additional three (3) counties: Blaine, Clearwater, and Lincoln.

~ Participating MMCP health plans (Blue Cross of Idaho and/or Molina Healthcare of Idaho) provide marketing and outreach to the Participants in these counties. Participants in these counties may enroll in the MMCP at any time; the effective date of enrollment will be prospective. Participants enrolled in the MMCP may switch health plans in counties with more than one operating health plan within 90 days of enrollment or during an annual enrollment period. Participants may opt out of the MMCP at any time, however, if they reside in a Mandatory or Passive Enrollment county, they will be enrolled in the IMPlus via the processes described below. Participants who choose not to enroll in or who disenroll from the MMCP in voluntary counties receive Medicaid benefits under the fee-for-service model.

Mandatory Enrollment:
~ IMPlus is a mandatory managed care program for Medicaid participants that are dually eligible for Medicare Parts and B and full Medicaid ("full dual eligible") and who have not enrolled in the voluntary MMCP program. (operated under a 1915(a) authority). IMPlus launched in select Idaho counties in November 2018.

~ IMPlus is currently available in the following twenty-one (21) counties where there are two (2) or more participating Health Plans: Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, and Twin Falls.

~ When the department identifies participants in these counties who have not opted to enroll in the MMCP, letter are sent informing these participants that they have 90 days to select a health plan or voluntarily enroll in the MMCP. Participants who fail to enroll in an IMPlus or MMCP plan will be auto-assigned into an IMPlus health plan. IMPlus effective enrollment date is prospective. Participants have the option to change health plans during the first 90 days. After that 90 days, Participants will only be able to change health plans during an annual enrollment period.

Passive Enrollment:
~ Passive enrollment operates in MMCP-only counties with only one (1) health plan option, Blue Cross of Idaho. In these

counties, the state introduced a passive enrollment process for participants who have not opted to enroll in the voluntary MMCP. These participants will are enrolled in the IMPlus under the health plan operating in that county unless they actively opt out. This passive enrollment process was introduced in 2020.

~ This passive enrollment process currently occurs in the nine (9) MMCP-only counties operating with only one (1) health plan, Blue Cross of Idaho: Adams, Benewah, Clark, Gooding, Jerome, Latah, Shoshone, Valley, and Washington. In 2022, passive enrollment will expand to an additional three (3) counties: Blaine, Clearwater, and Lincoln.

~ When the department identifies dual eligible participants in these counties who have not opted to enroll in the voluntary MMCP, letters are sent providing notification to these participants that if they do not choose to enroll in MMCP or do not opt out of passive enrollment, they will be enrolled in IMPlus managed by Blue Cross. The letter provides two (2) ways to contact the state in order to opt out, enroll, or ask any questions: a) By returning the enclosed enrollment form; or b) by contacting the Beneficiary Support Specialist line. Participants have 90 days to opt out or voluntarily enroll in the MMCP. Participants who fail to opt out of IMPlus or to enroll in the MMCP will be auto-assigned into the IMPlus operated by Blue Cross. IMPlus effective enrollment date for these passively-enrolled participants is prospective. Participants enrolled in IMPlus in these counties are able to disenroll from IMPlus at any time. Participants who disenroll from or opt out of IMPlus and who do not enroll in MMCP in voluntary counties with passive enrollment receive Medicaid benefits under the fee-for-service model.

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

○ Competitive procurement method (RFP, RFA).

◉ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the MCOs:

The state will contract with any health plan that receives CMS authority to operate in Idaho, and that elects to cover this MMCP ABP population, as long as the health plan meets all certification requirements and contractual obligations.

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. Yes

List the benefits or services that will be provided apart from the MCO, and explain how they will be provided. Add as many rows as needed.

Add	Benefit/service	Description of how the benefit/service will be provided	Remove
Add	Adult Dental Services	Adult Dental Services are described in ABP8-MC Dental.	Remove

MCO service delivery is provided on less than a statewide basis. Yes

The limited geographic area where this service delivery system is available is as follows:

◉ MCO service delivery is available only in designated counties.

○ MCO service delivery is available only in designated regions.

○ MCO service delivery is available only in designated cities and municipalities.

○ MCO service delivery is available in some other geographic area (geographic area must not be smaller than a zip code).

Specify counties:

~ The MMCP is currently available in the following thirty (30) voluntary counties: Ada, Adams, Bannock, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Clark, Elmore, Fremont, Gem, Gooding, Jefferson, Jerome, Kootenai, Latah, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Shoshone, Twin Falls, Valley, and Washington.

~ IMPlus is currently available in the following twenty-one (21) mandatory counties: Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, and Power, and Twin Falls.

~ Effective April 1, 2022, MMCP/IMPlus will expand into the following three (3) counties with only one operating health plan: Blaine, Clearwater, and Lincoln. Enrollment in MMCP is voluntary. Participants who do not choose to enroll in MMCP will be passively enrolled in IMPlus. Participants who opt out of MMCP/IMPlus will remain on FFS.

MCO Participation Exclusions

Individuals are excluded from MCO participation in the Alternative Benefit Plan: Yes

Select all that apply:

☐ Individuals with other medical insurance.

☐ Individuals eligible for less than three months.

☐ Individuals in a retroactive period of Medicaid eligibility.

☒ Other:

General MCO Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

◉ Mandatory participation.

○ Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in MCOs:

Mandatory Participation:
~ Participants enrolled in this ABP are required to enroll in a health plan when they reside in a county with two (2) or more operating health plans.

Voluntary Participation:
~ Participants enrolled in this ABP are not required to enroll in a health plan when they reside in a county where only the MMCP is available but may voluntarily enroll in the MMCP.

~ Participants residing in a voluntary county with only one (1) operating MMCP health plan may be passively enrolled in the IMPlus but may opt out prior to the enrollment begin date or may disenroll at any time.

Non-Participation:
~ Dual-eligible participants who reside in counties where there is no operating health plan (or who opt out of participation in a voluntary county) receive Medicaid benefits on this MMCP ABP via the Fee-For-Service model.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Alternative Benefit Plan

State Name: Idaho

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ID - 22 - 0014

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Idaho Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: ID - 22 - 0014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Idaho Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: ID - 22 - 0014

Payment Methodology ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- M

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- (•) The state/territory is amending one existing benefit package for the population defined in Section 1.
- ( ) The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Medicare/Medicaid Coordinated ABP

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- (•) Benchmark Benefit Package.
- ( ) Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ( ) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ( ) State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ( ) A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- (•) Secretary-Approved Coverage.
  - ( ) The state/territory offers benefits based on the approved state plan.
  - (•) The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Idaho offers benefits that are based on Idaho's Base Benchmark Small Group plan, Preferred Blue along with additional services that are appropriate for the Medicaid Participants choosing this plan.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. Yes

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

- The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
- The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid State plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130801

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- M

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

The state/territory is proposing "Secretary-Approved Coverage" as its section 1937 coverage option. Yes

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

The state/territory must provide a benefit by benefit comparison of the benefits in its proposed Secretary-Approved Alternative Benefit Plan with the benefits provided by one of the section 1937 Benchmark Benefit Packages or the standard full Medicaid state plan under Title XIX of the Act. Submit a document indicating which of these benefit packages will be used to make the comparison and include a chart comparing each benefit in the proposed Secretary-Approved benefit package with the same or similar benefit in the comparison benefit package, including any limitations on amount, duration and scope pertaining to the benefits in each benefit package.

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Preferred Blue, Blue Cross of Idaho Health Services, Inc.

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services — Collapse All ☐

Benefit Provided: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Specialist Visit
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Selected services require prior authorization.

Benefit Provided: Other Practitioner Office Visit
Source: Base Benchmark Small Group

Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Selected services require prior authorization.

Remove

Benefit Provided:

Outpatient Facility Fee (e.g., ASC)

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Ambulatory Surgery Center (ASC).

Selected services require prior authorization.

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Selected services require prior authorization.

Benefit Provided:

Urgent Care Centers or Facilities

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Chiropractic Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

Six (6) visits per year

Duration Limit:

None

Scope Limit:

Manual manipulation of the spine to correct subluxation.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

See "other 1937" benefits for additional services.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Renal Dialysis

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Respiratory Therapy

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Enterostomal Therapy

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Home IV Therapy

Source:
Base Benchmark Small Group

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Hospice

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services — Collapse All

Benefit Provided: Emergency Room Services

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Emergency Transportation/Ambulance

Source: Base Benchmark Small Group — Remove

Authorization: Retroactive Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All

Benefit Provided: Inpatient Hospital Services (e.g., Hospital Stay)
Source: Base Benchmark Small Group
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Once an individual exhausts the Medicare Part A lifetime limit of reserve days for inpatient hospital care, the services will be covered by Medicaid. The medical necessity of a continued stay is reviewed by the Department on the first day of Medicaid responsibility.

Selected services require prior authorization.

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Selected services require prior authorization.

Benefit Provided: Radiation Therapy: Inpatient
Source: Base Benchmark Small Group

Authorization: None
Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None
Duration Limit: None

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care — Collapse All

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Delivery and All Inpatient Services-Maternity Care

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Freestanding Birth Centers are not recognized providers by Idaho Medicaid and are not licensed in the State.

Add

Alternative Benefit Plan

Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided: Substance Use Disorder Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: MH/BH Inpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Mental Health/Behavioral Health Inpatient Services.

Once an individual exhausts the Medicare Part A 190 days lifetime limit for inpatient mental health care in a psychiatric hospital, the services will be covered by Medicaid. The medical necessity of a continued stay is reviewed by the Department on the first day of Medicaid responsibility.

The MH/BH inpatient authorization requirements were created to ensure that payments are consistent with efficiency, economy, and quality of care, and that utilization management requirements for inpatient mental health services found in 42 CFR 456.170-181 are met.

Services are not provided in an IMD.

Benefit Provided: MH/BH Outpatient Services

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Remove

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The MMCP ABP covers Mental/Behavioral Health Outpatient Services in the same way the Base Benchmark covers these services, with the exception of Residential Treatment. There are no certified Psychiatric Residential Treatment Facilities located in the State of Idaho, and individuals under the age of 21 are not eligible for enrollment in the MMCP ABP.

Services covered include Group therapy, Family and individual therapy, ECT therapy, IOP, PHP, and medication management.

PHP requires prior authorization - Other MH/BH services do not.

Program Description
Physician Services: Section 1905(a)(5)(A) of the Act.
Medical Care furnished by licensed practitioners: Section 1905(a)(6) of the Act.
Certified Pediatric or Family Nurse Practitioners' Services: Section 1905(a)(21) of the Act.

Benefit Provided: Substance Use Disorder Inpatient Services

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The MMCP ABP covers Substance Use Disorder Inpatient Services with services that are the same as the Base Benchmark, with the exception of Residential Treatment services. There are no certified Psychiatric Residential Treatment Facilities located in the State of Idaho.

The substance use disorder inpatient authorization requirements were created to ensure that payments are consistent with efficiency, economy, and quality of care and that utilization management requirements for inpatient mental health services found in 42 CFR 456.170-181 are met.

Once an individual exhausts the Medicare Part A lifetime limit of reserve days for inpatient hospital care, the services will be covered by Medicaid. The medical necessity of a continued stay is reviewed by the

Department on the first day of Medicaid responsibility.

Services are not provided in an IMD.

Remove

Benefit Provided:

Community-Based Rehabilitation Services

Source:

Secretary-Approved Other

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Program Description: Community-based rehabilitation services (CBRS); 1905(a)(13)(C) of the Act.

- CBRS services consist of evidence-based practices that are restorative interventions or interventions that reduce disability and that are provided to participants with serious, disabling mental illness, emotional disturbance or substance use disorders for the purpose of increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology, or eliminating or reducing alcohol and drug use and implementing structure and support to achieve and sustain recovery, and ensuring a satisfactory quality of life. Services include treatment planning, and the provision and coordination of treatments and services delivered by multidisciplinary teams under the supervision of a licensed behavioral health professional staff, physician or nurse.

- Interventions for psychiatric symptomatology will use an active, assertive outreach approach, including use of a comprehensive assessment and the development of a community support treatment plan, ongoing monitoring and support, medication management, skill restoration, crisis resolution and accessing needed community resources and supports.

- Interventions for substance use disorders will include substance use disorder treatment planning, psycho-education and supportive counseling, which are provided to achieve rehabilitation and sustain recovery and restoration of skills needed to access needed community resources and supports. These services are provided in conjunction with any professional or therapeutic behavioral health services identified as necessary for the participant.

- Services may be provided by one of the following contracted professionals when provided within the scope of their practice:
  1) Licensed physician
  2) Advanced Practice Registered Nurse
  3) Physician Assistant
  4) Licensed Social Worker
  5) Licensed Counselor
  6) Licensed Marriage and Family Therapist
  7) Providers who hold at least a Bachelor's degree, are licensed or certified in their fields (i.e., Adult or Children's Certificate in Psychosocial Rehabilitation), and who meet requirements of Idaho Department of Health and Welfare or its Contractor

8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

Remove

Add

Alternative Benefit Plan

■ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The MMCP ABP covers at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class. In addition to the drugs covered by Medicare, some prescription drugs are covered for individuals under their Idaho Medicaid benefits.

See "Other 1937 Benefits" for services provided in excess of the Base Benchmark.

Alternative Benefit Plan

■ Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All ☐

Benefit Provided: Home Health Care Services: Skilled Nursing

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Skilled Nursing services provided through a Home Health Agency. Such services must not constitute Custodial Care, and the participant's physician must review the care at least every sixty (60) days.

Benefit Provided: Outpatient Rehabilitation Services: PT, OT, SLP

Source: Base Benchmark Small Group — Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: Twenty (20) visits per year for rehabilitation

Duration Limit: None

Scope Limit: PT, OT, SLP rehabilitation services are for the purpose of restoring certain functional losses due to disease, illness or injury.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The Base Benchmark limit is up to 20 visits for all occupational therapy (OT), speech-language pathology services (SLP) and physical therapy (PT) combined, and includes both rehabilitation and habilitation. To comply with 45 CFR 156.115(a)(5)(iii), Idaho Medicaid is establishing separate, equal 20-visit limits each for rehabilitation and habilitation. Services are not provided through a Home Health Agency.

All services require prior authorization.

See "Other 1937 Benefits" for additional services.

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Items that can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of injury, disease or illness, and are appropriate for use in any setting in which normal life activities take place.

Benefit Provided:
Skilled Nursing Facility

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Skilled Nursing Facility services for rehabilitation.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
See "Other 1937 Benefits" for services in excess of the Base Benchmark limit of 30 days per year.

Benefit Provided:
Outpatient Habilitation: OT, PT, SLP Services

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
Twenty (20) visits per year for habilitation

Duration Limit:
None

Scope Limit:
PT, OT, SLP services related to developing skills and functional abilities necessary for daily living and skills related to communication of persons who have never acquired them.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
The Base Benchmark limit is up to 20 visits for all occupational therapy (OT), speech-language pathology services (SLP) and physical therapy (PT) combined, and includes both rehabilitation and habilitation. To comply with 45 CFR 156.115(a)(5)(iii), Idaho Medicaid is establishing separate, equal 20-visit limits each for rehabilitation and habilitation. Services are not provided through a Home Health Agency.

All services require PA.

See "Other 1937 Benefits" for additional services.

Remove

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services — Collapse All

Benefit Provided: Diagnostic Test (X-ray and Lab Work)

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Imaging (CT/PET Scans, MRIs, Nuclear Cardiology)

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

☑ Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The MMCP- ABP will provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for participants recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventive Care/Screening/Immunization

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The MMCP ABP includes an annual wellness visit to develop or update a personalized prevention plan based on current health and risk factors.

Benefit Provided: Diabetes Education

Source: Base Benchmark Small Group

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Tobacco Cessation Counseling

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Covered in accordance with USPSTF recommendations.

Add

Alternative Benefit Plan

Essential Health Benefit 10: Pediatric services including oral and vision care — Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Secretary-Approved Other

Remove

Authorization:
None

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
This plan is targeted for adults who are on Medicare. No children have been enrolled.

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All ☐

Base Benchmark Benefit that was Substituted:

Residential Treatment

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

The Department substitutes Community-based Rehabilitation Services for Residential Treatment (part of the EHB 5 Mental/Behavioral Health Outpatient services and also Substance Use Disorder Inpatient services): There are no Psychiatric Residential Treatment Facilities licensed or certified in the State of Idaho.

This is an IMD.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:
Non-Emergency Care When Traveling Outside the U.S.

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:
Non-covered in accordance with federal statute.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:
Orthodontia: Child

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:
The Base Benchmark Plan only provides coverage of these services for children. Children under the age of 21 are excluded from the MMCP.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:
Eyeglasses for Children

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:
The Base Benchmark Plan only provides coverage of these services for children. Children under the age of 21 are excluded from the MMCP.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:
Dental Check-ups for Children

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:
The Base Benchmark Plan only provides coverage of these services for children. Children under the age of 21 are excluded from the MMCP.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:
Basic Dental Care: Child

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:
The Base Benchmark Plan only provides coverage of these services for children. Children under the age of 21 are excluded from the MMCP.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:
Major Dental Care: Child

Source: Base Benchmark

Explain why the state/territory chose not to include this benefit:

The Base Benchmark Plan only provides coverage of these services for children. Children under the age of 21 are excluded from the MMCP.

Remove

Add

Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided:
Nursing Facility: Custodial Care

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Nursing facility services; Section 1905(a)(4)(A) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Nursing Facility: Custodial Care

Long-term custodial care is covered when provided in a licensed skilled nursing facility certified by Medicare.

Once a participant reaches the Medicare Part A first 100 days of post hospitalization limit for skilled nursing facility services, the services will be covered by Medicaid.

This service is not covered by the Base Benchmark. The Department requires that the nursing facility services include at least the items and services specified in 42 CFR 483.10(c)(8)(i).

Other 1937 Benefit Provided:
Dental Services: Adults

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Dental services; 1905(a)(10) of the Act

Other services covered by the MMCP, but not covered by the Base Benchmark: Adult Dental Services
Program Description: Dental services; 1905(a)(10) of the Act

All adult participants over age 21 receive all medically necessary dental services, including the following preventative and restorative services:
~ Preventive dental services:

- Oral exam every 12 months
- Cleaning every six months
- Fluoride treatment every 12 months
- Dental X-rays every 12 months (Full mouth or Panoramic every 36 months)

~ Restorative Dental Services:
- Medically necessary exams
- Fillings are covered once in a 24-month period per tooth/surface
- Simple and surgical extractions
- Endodontic services include therapeutic pulpotomy and pulpa debridement.
- Periodontic services include scaling and root planing, full mouth debridement
- Periodontal maintenance is covered up to 2 visits every 12 months.

~ Dentures:
-Dentures are covered once every 5 years.

Limitations may be exceeded if medically necessary.

Exclusions - The following non-medically necessary cosmetic services are excluded from payment under the Enhanced Benchmark Benefit Package covered under the State Plan:
~ Drugs supplied to dental patients for self-administration other than those allowed by applicable Department rules.
~ Non-medically necessary cosmetic services are excluded from payment.

The Department may require prior approval for specific elective dental procedures.

Remove

Other 1937 Benefit Provided:

Personal Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

16 hours per week

Duration Limit:

None

Scope Limit:

Medically oriented care services related to a participant's physical or functional requirements provided in the participant's home or personal residence.

Other:

Program Description: Personal Care Services; Section 1905(a)(24) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Personal Care Services.

PCS include medically oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence.

The provider must deliver at least one (1) of the following services for a participant needing that service (as identified by the Department Nurse Reviewer):
a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care;
b. Assistance with bladder or bowel requirements that may include helping the participant to and from the

bathroom or assisting the participant with bedpan routines;
c. Assistance with food, nutrition, and diet activities, including preparation of meals if incidental to medical need;
d. The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the participant with developmental disabilities;
e. Assisting the participant with physician-ordered medications that are ordinarily self-administered, when the provider has completed an Idaho State Board of Nursing approved training program and in accordance with Idaho state statute and regulations governing assistance with medications;
f. Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met:
  i. The task is not complex and can be safely performed in the given participant care situation;
  ii. A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs;
  iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly;
  iv. Any change in the participant's status or problems related to the procedure must be reported immediately to the RN.

PCS may also include non-medical tasks. In addition to performing at least one (1) of the services listed above, the provider may also perform the following services, if no natural supports are available:
a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded.
b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment.
c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant.

Services are furnished to a participant who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for people with intellectual disabilities, or institution for mental diseases.

Services are authorized for the individual by a physician in accordance with a plan of treatment.

PCS are furnished in the participant's place of residence, which may include:
• Personal Residence.
• 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.
• Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner.

Personal assistance agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record and in fact.

Provider Qualifications: Personal care services are provided by Licensed Professional Nurse (RN), Licensed Practical Nurse (LPN), Certified Nursing Assistant (CNA) (person listed on the CNA Registry who performs selected nursing services under the supervision of a registered professional nurse

who has successfully completed a training program and holds a Certificate of Training meeting Federal eligibility requirements for listing on the Registry) or personal assistant (must be at least eighteen (18) years of age and receive training to ensure the quality of services). Services may be provided by any qualified individual who is qualified to provide such services and who is not a member of the individual's family (legally responsible relative).

Freedom of Choice: The provision of personal care services will not restrict an individual's free choice of providers-section 1902(a)(23) of the Act. Eligible recipients (or a parent, legal guardian or the state in loco parentis) will have free choice of providers, the setting in which to reside, and a different personal care assistant, CNA, LPN, or RN if desired under the plan.

Personal care service providers will receive training in the following areas:
- Participant confidentiality - Knowledge of the limitations regarding participant information and adherence to Health Insurance Portability and Accountability Act (HIPAA) and agency confidentiality guidelines.
- Universal precautions - Identifies how infection is spread, proper hand washing techniques, and current accepted practice of infection control; knowledge of current accepted practice of handling and disposing of bodily fluids.
- Documentation - Knowledge of basic guidelines and fundamentals of documentation.
- Reporting - Knowledge of mandatory and incident reporting, as well as role in reporting condition change.
- Care plan implementation - Knowledge of utilization of care plan when delivering participant services.

Based on the participant's Department-assessed needs, the personal care services provider may receive training on basic personal care and grooming, toileting, transfers, mobility, assistance with food preparation, nutrition, and diet; assistance with medications, and RN-delegated tasks.

Providers who are expected to carry out training programs for developmentally disabled participants must be supervised at least every ninety (90) days by a Qualified intellectual disability professional (QIDP) as defined in 42 CFR 483.430(a).

Remove

Other 1937 Benefit Provided:

Outpatient Rehab: OT, PT, and SLP

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services for developing skills and functional abilities necessary for daily living and skills related to communication of persons who have never acquired them

Other:

Program Description: Physical therapy and related services; Section 1905(a)(11) of the Act.

Services in excess of the Base Benchmark: Rehabilitation and Habilitation Services.

MMCP ABP covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark and State Plan visit limits when medically necessary.

Alternative Benefit Plan

Other 1937 Benefit Provided:

ICF/ID

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Program Description: Services in an intermediate care facility for individuals with intellectual disabilities; Section 1905(a)(15) of the Act.

The Department will comply with all requirements at 42 CFR 440.150.

Other services covered by the Department, but not covered by the Base Benchmark: ICF/ID - Intermediate Care Facility for Individuals with Intellectual Disabilities.

Other 1937 Benefit Provided:

Prescription Drugs

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Program Description: Prescription Drugs: Section 1905(a)(12) of the Act.

Prescription Drugs: In excess of Base Benchmark.

Under this plan, the Medicare Advantage Plan becomes responsible for the Medicare-excluded drugs and is expected to provide this coverage through the same network of providers as the Medicare Part D drugs.

The Medicare/Medicaid Coordinated Plan includes the following Medicare-excluded or otherwise restricted drugs or classes of drugs.

Prescription cough and cold symptomatic relief.

Legend therapeutic vitamins, which include injectable vitamin B-12, vitamin K and analogues, and legend folic acid;

• Oral legend drugs containing folic acid in combination with vitamin B-12 and/or iron salts, without additional ingredients; and
• Legend vitamin D and analogues.

Remove

Non-legend products, which include:
• Federal legend medications that change to non-legend status, as well as their therapeutic equivalents. The Director determines that non-legend drug products are covered based on appropriate criteria including safety, effectiveness, clinical outcomes, and the recommendation of the P&T Committee.
• Other non-legend drug products approved for coverage by the Director of the Department of Health and Welfare based on the determination of the Pharmacy and Therapeutics Committee that the non-legend product is therapeutically interchangeable with legend drugs in the same pharmacological class based on evidence comparison of efficacy, effectiveness, and safety and determined by the Department to be a cost-effective alternative.

Additional Covered Drug Products. Additional drug products will be covered as follows:
• Legend prenatal vitamins for pregnant or lactating individuals;
• Legend folic acid;
• Oral legend drugs containing folic acid in combination with vitamin B-12 and/or iron salts, without additional ingredients; and
• Legend vitamin D and analogues.

Other 1937 Benefit Provided:

Home Health Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Program Description: Home Health Care Services; Section 1905(a)(7) of the Act.

Services covered in excess of the Base Benchmark: The MMCP ABP contractor covers medically necessary services in accordance with Medicare criteria.

Coverage includes:
- Home health aide services;
- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Medical and social services; and
- Medical equipment and supplies.

Other 1937 Benefit Provided:

Nursing Facility: Rehabilitation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Nursing facility services; Section 1905(a)(4)(A) of the Act.

Services in excess of the Base Benchmark: Skilled Nursing Facility (SNF).

The Base Benchmark covers SNF for rehabilitation and limits care to 30 days per year.

The contractor will cover rehabilitative skilled nursing facility services in excess of the 30 days per year covered by the Base Benchmark up to the 90 days covered by Medicare if the participant is showing progress toward rehabilitation goals.

The Department will cover:
- SNF services after the Medicare Part A first 100 days of post hospitalization limit.
- Medically necessary SNF services when there has been no hospitalization prior to admission to the skilled nursing facility.

Other 1937 Benefit Provided:
Podiatrist Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services to diagnose and treat medical conditions affecting the foot, ankle and related structures.

Other:
Program Description: Medical Care furnished by licensed practitioners; Section 1905(a)(6) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Podiatrist Services.

Routine foot care is not covered.

Other 1937 Benefit Provided:
Diabetes Education

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Other diagnostic, screening, preventive, and rehabilitative services; Section 1905(a)(13) of the Act.

Services in excess of the Base Benchmark: Diabetes Education.

The Base Benchmark has eliminated all amount limits for diabetes education. The MMCP ABP covers services up to the Medicare-allowed maximum of 10 hours per year.

Other 1937 Benefit Provided:
Bariatric Surgery

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Physician Services; Section 1905(a)(5)(B) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Bariatric Surgery.

Covered when covered by Medicare - some bariatric surgical procedures, like gastric bypass surgery and laparoscopic banding surgery, are covered when performed by a Medicare provider and when conditions related to morbid obesity are met.

Other 1937 Benefit Provided:
Chiropractic Care

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Manual manipulation of the spine to treat a subluxation condition.

Remove

Other:

Program Description: Medical care furnished by licensed practitioners; Section 1905(a)(6) of the Act.

The MMCP ABP covers services in excess of the Base Benchmark and limits specified in Idaho Code. All medically necessary chiropractic services are covered. Claims may be reviewed for medical necessity.

Other 1937 Benefit Provided:

Audiology

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Covered services include diagnostic hearing and balance evaluations performed by a qualified provider to obtain a differential diagnosis and to determine if the participant needs medical treatment.

Other 1937 Benefit Provided:

Targeted Service Coordination: Adults with DD

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Program Description: Targeted Case Management Services; Section 1905(a)(19) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Targeted Service Coordination for Adults with Developmental Disabilities.

Target Group (42 CFR 441.18(a)(8)(i) and 441.18(a)(9)):
Adults age 18 and older, who have a developmental disability diagnosis, and who require and choose assistance to access services and supports necessary to maintain independence in the community.

For targeted service coordination provided to individuals in medical institutions: [Olmstead letter #3]

Target group is comprised of individuals transitioning to a community setting, and targeted service coordination services will be made available for up to the last 60 consecutive days of the covered stay in the medical institution.

Areas of State in which services will be provided: Entire State.

Services are not comparable in amount, duration and scope - 1915(g)(1).

Definition of services: [42 CFR 440.169]
Targeted service coordination services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services.

Target service coordination includes the following assistance:

- Comprehensive assessment and annual reassessment of an individual to determine the need for any medical, educational, social or other services and update the plan. These assessment activities include up to six hours of:
  - Taking client history;
  - Identifying the individual's needs and completing related documentation;
  - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

  Additional hours may be prior authorized if medically necessary.

- Development (and periodic revision) of a specific care plan that:
  - Is based on the information collected through the assessment;
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized healthcare decision-maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities:
  - To help an eligible individual obtain needed services, including activities that help link the individual with:
    - √ Medical, social, educational providers; or
    - √ Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

- Monitoring and follow-up activities:
  - Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals, and may be conducted as frequently as necessary, including at least one annual monitoring to assure that the following conditions are met:
    - √ Services are being furnished in accordance with the individual's care plan;
    - √ Services in the care plan are adequate; and
    - √ If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.

Targeted service coordination may include:

- Contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:
- Targeted service coordination must only be provided by a service coordination agency enrolled as a Medicaid provider. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator.
- Agencies must provide supervision to all service coordinators and paraprofessionals.
- Any willing, qualified public or private service coordination agency may be enrolled.

Agency Supervisor: Education and Experience
- Master's degree in a human services field from a nationally accredited university or college and twelve (12) months' experience working with adults with developmental disabilities; or
- Bachelor's degree in a human services field from a nationally accredited university or college or licensed professional nurse (RN) and twenty-four (24) months' experience working with adults with developmental disabilities.

Service Coordinator: Education and Experience
- Minimum of a Bachelor's degree in a human services field from a nationally accredited university or college and twelve (12) months' experience working with adults with developmental disabilities; or be a licensed professional nurse (RN) and have twelve (12) months' experience working with adults with developmental disabilities. Individuals who meet the education or licensing requirements but do not have the required work experience may work as a service coordinator under the supervision of a qualified service coordinator while they gain this experience.

Paraprofessional: Education and Experience
- Be at least eighteen (18) years of age, have a minimum of a high school diploma (or equivalency), be able to read and write at the level of the paperwork and forms involved in the provision of the service, and have twelve (12) months' experience with adults with developmental disabilities. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the service plan.

Freedom of choice: The State assures that the provision of targeted service coordination services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act. Any willing, qualified private agency may be enrolled as a service coordination agency.
- Eligible recipients will have free choice of the providers of targeted service coordination services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Access to Services: The State assures that:
- Targeted service coordination services will be provided in a manner consistent with the best interests of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902(a)(19)]
- Individuals will not be compelled to receive targeted service coordination services, condition receipt of targeted service coordination services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of targeted service coordination services; [section 1902 (a)(19)]
- Providers of targeted service coordination services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for targeted service coordination services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
The State assures that providers maintain case records that document for all individuals receiving targeted

service coordination as follows [42 CFR 441.18(a)(7)]:
• The name of the individual.
• The dates of the targeted service coordination services.
• The name of the provider agency and the person providing the targeted service coordination services.
• The nature, content, units of the targeted service coordination services received and whether goals specified in the care plan have been achieved.
• Whether the individual has declined services in the care plan.
• The need for, and occurrences of, coordination with other service coordinators.
• A timeline for obtaining needed services.
• A timeline for reevaluation of the plan.

Limitations:
Targeted service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Targeted service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the targeted service coordination activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by a foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(c))

FFP is only available for targeted service coordination services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for service coordination that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Additional limitations:
• Reimbursement for ongoing service coordination is not reimbursable prior to the completion of the assessment and service plan.
• In order to assure that no conflict of interest exists, providers of targeted service coordination may not provide both service coordination and direct services to the same Medicaid participant.
• Reimbursement is not allowed for missed appointments, attempted contacts, leaving messages, travel to provide the service, documenting services or transporting the participant.

Remove

Other 1937 Benefit Provided:
Transition Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
72 hours per benefit cycle

Duration Limit:
None

Scope Limit:
Limited to the target population

Other:

Program Description: Targeted Case Management Services; 1905(a)(19) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Transition Management services for Adults in Institutions.

Target Group (42 CFR 441.18(a)(8)(i) and 441.18(a)(9):
Target group includes adult individuals over the age of 18 transitioning to a community setting. Case management services will be made available after forty-five (45) consecutive days of a covered stay in a medical institution. The target group does not include individuals between the ages of 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates in public institutions.

For transition management services provided to individuals in medical institutions: [Olmstead letter #3]

Target group is comprised of individuals transitioning to a community setting and transition management services will be made available after all applicable Medicare Part A benefits have been exhausted.

Areas of State in which services will be provided: Entire State.

Services are not comparable in amount duration and scope - 1915(g)(1).

Definition of services: [42 CFR 440.169]
Transition management is a service furnished to assist participants, eligible under the State plan, in gaining access to needed medical, social, educational and other services.

Transition management includes the following assistance:
• Initial Comprehensive assessment of a participant to determine the need for any medical, educational, social or other services necessary to transition to the community. a home and community-based setting. The assessment is to be completed at the time of the initial referral. These assessment activities include:
o Taking client history;
o Identifying the participant's needs and completing related documentation;
o Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the participant.

• Development (and periodic revision) of a specific transition care plan that:
o Is based on information collected through the assessment;
o Specifies the goals and actions to address the medical, social, educational, and other services needed by the participant to successfully transition to the community;
o Includes activities such as ensuring the active participation of the participant, and working with the participant (or the participant's authorized health care decision-maker) and others to develop those goals; and
o Identifies a course of action to respond to the assessed needs of the participant related to transitioning to the community.

• Referral and related activities:
o To help a participant obtain needed services including activities that help link the participant with:
□ Identifying and securing accessible home and community-based housing;
□ Identifying and securing necessary and appropriate furnishings/supplies for the participant's residence;
□ Medical, social, educational providers; or
□ Other programs and services capable of providing needed services, such as making referrals to

providers for needed services and scheduling appointments for the participant.

- Monitoring and follow-up activities:

o Activities, and contacts, necessary to ensure the transition care plan is implemented and adequately addresses the individual's needs. These activities, and contacts, may be with the participant, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary, including at least one monitoring activity within twelve (12) months of discharge to assure following conditions are met:

- Services are being furnished in accordance with the participant's transition care plan;
- Services in the transition care plan are adequate; and
- If there are changes in the needs or status of the individual, necessary adjustments are made to the transition care plan and service arrangements with providers

o Monitoring will occur as part of each bureau's oversight of prior authorization and service plan oversight, in addition to being incorporated into the 1915(c) waiver programs' overall quality assurance oversight.

Transition management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the participant to access services.

The Department will prior authorize services exceeding the amount limit of seventy-two (72) hours, to be used over the two (2) year benefit cycle, when such services are determined to be medically necessary. There is no hard limit/cap to use of the Transition Management benefit.

Qualifications of providers:

- Transition management must only be provided by an agency enrolled as a Medicaid provider with one of the following specialties: Behavior Consultation/Crisis Management, Nursing Service Agency, PCS Agency, PCS Case Management Agency, Social Work Services, TBI Agency, DD (Developmental Disability) Agency, or DD Case Management Agency. An agency is a business entity that provides oversight of billed transition management services.
- Any willing, qualified public or private agency may be enrolled to provide transition management services.

Transition Manager: Education

- Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college; or three (3) years of supervised work experience with the population being served.

Transition management providers will successfully complete a State approved Transition Manager training prior to providing any transition management services, which will include the following:

- Participant confidentiality – Knowledge of the limitations regarding participant information and adherence to Health Insurance Portability and Accountability Act (HIPAA) and agency confidentiality guidelines.
- Documentation – Knowledge of basic guidelines and fundamentals of documentation.
- Transition care plan development and implementation – Knowledge of development and utilization of transition care plan when delivering participant services.
- Monitoring requirements – Developing a communication plan and schedule for post-transition progress

Freedom of choice: The State assures that the provision of transition management will not restrict a participant's free choice of providers in violation of section 1902(a)(23) of the Act. Eligible participants will have a free choice of providers, the qualified home and community-based setting in which to reside, and a different transition manager if desired under the plan.

Access to Services: The State assures that:

- Transition management will be provided in a manner consistent with the best interests of

recipients and will not be used to restrict a participant's access to other services under the plan; [section 1902 (a)(19)]

- Participants will not be compelled to receive transition management, condition receipt of transition management on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of transition management; [section 1902 (a)(19)]
- Providers of transition management do not exercise the agency's authority to authorize or deny the provision of other services under the plan
- Participants through the month of their twenty-first (21st) birthday, pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Payment (42 CFR 441.18(a)(4)):
Payment for transition management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records: The State assures that providers maintain case records that document the following for all participants receiving transition management services targeted service coordination [42 CFR 441.18(a)(7)]:

- The name of the participant.
- The dates of the transition management services.
- The name of the provider agency and the person providing the transition management services.
- The nature, content, and units of the transition management services received, and whether goals specified in the care plan have been achieved.
- Whether the participant has declined services in the care plan.
- The need for, and occurrences of, coordination with other service coordinators.
- A timeline for obtaining needed services.
- A timeline for reevaluation of the plan.

Limitations:
Transition management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the transition management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) § 4302). Transition management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the transition management activities constitute the direct delivery of underlying medical, educational, social, or other services to which a participant has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(c))

FFP is only available for transition management if there are no other third parties liable to pay for such services, including reimbursement under a medical, social, educational, or other program.(§§1902(a)(25) and 1905(c))

Additional limitations:

- Reimbursement for ongoing transition management is not allowed prior to the completion of the assessment and transition care plan.
- To assure that no conflict of interest exists, providers of transition management may not provide both transition management services and direct services to the same Medicaid participant.

Remove

Alternative Benefit Plan

Add

Alternative Benefit Plan

☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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