State Plan Amendment #11 for the Idaho State Children's Health Insurance Program

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Effective Date: January 1, 2011 Approval Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____Idaho_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
LESLIE M. CLEMENT, MEDICAID ADMINISTRATOR DATE

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Leslie M. Clement	Position/Title: State Medicaid Director Administrator, Division of Medicaid
Name: Dave Taylor	Position/Title: Chief Financial Officer Acting Administrator, Division of Management Services
Name: Robin Pewtress	Position/Title: State CHIP Director Division of Medicaid

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 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Effective Date: January 1, 2011 Approval Date:

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☒ A combination of both of the above.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Date Original Plan Submitted: February 17, 1998
Date Approved: June 15, 1998
Effective Date: October 1, 1997

Amendment #1 Description: Change income limit from 160% FPG to 150% FPG
Submitted: October 13, 1998
Approved: December 4, 1998
Effective date: July 1, 1998

Effective Date: January 1, 2011 Approval Date:

Amendment #2 Description: Program design changes to-

- increase coordination of efforts across agencies
- simplify the application process, and
- improve media and outreach approaches

Submitted: March 10, 2000
Approved: March 1, 2001
Effective date: January 1, 2000

Amendment #3 Description: Technical changes to conform to model template
Revised outreach strategies
Submitted: June 28, 2002
Approved: September 19, 2002
Effective date: July 1, 2002

Amendment #4 Description: Establish separate program
Submitted: February 25, 2004
Approved: June 10, 2004
Effective date: July 1, 2004

Amendment #5 Description: Revise benefit package of separate program
Submitted: August 30, 2004
Approved: January 13, 2005
Effective date: July 1, 2004

Amendment #6 Description: Removal of enrollment cap
Submitted: June 9, 2005
Approved: September 7, 2005
Effective date: June 1, 2005

Amendment #7 Description: Addition of child health services initiative
(Healthy Schools)
Submitted: April 28, 2006
Approved: May 25, 2006
Effective date: July 1, 2006

Amendment #8 Description:

- Lower the income limit of separate program from 150% to 133%
- Remove resource limit
- Incorporate Basic and Enhanced Benchmark Benefit Packages
- Changes to premium structure

Submitted: May 5, 2006
Approved: May 25, 2006
Effective date: July 1, 2006

Amendment #9 Description: Addition of Wellness Preventive Health Assistance
Addition of co-pays

Submitted: January 24, 2007
Approved: September 28, 2007
Effective date: January 1, 2007 (Wellness PHA)
February 1, 2007 (co-pays)

Amendment #10 Description:

- Addition of Substance Abuse Treatment Services
- Addition of Independent Therapists for Speech Language Pathology (SLP) Services
- Reduce limits for Psycho-Social Rehabilitation, Partial Care and Developmental Disability Agency Services
- ~~Reduction in Transportation Services~~

Submitted: March 17, 2009
Approved:
Effective date: November 1, 2008 (Substance Abuse Treatment & SLP)
January 1, 2009 (Reduction in Mental Health & DDA)
~~April 1, 2009 (Reduction in Transportation)~~

Amendment #11 Description:

- Contact Lens Coverage Modification
- Mental Health Assessment Annual Limitation
- Mental Health Treatment Plan Limitation
- Collateral Contact & Partial Care Elimination
- PSR Limitation
- DDA Assessment Annual Limitation
- Incorporation of Dental Services Template (Sections 6.2-D & 10.3-D)

Submitted: February 28, 2011
Approved:
Effective date:

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

Idaho is a predominantly rural state. Of Idaho's 44 counties, 17 are classified as frontier (less than 6 people per square mile) and an additional 19 are classified as rural (those that do not contain a population center of more than 20,000 people). The rural nature of Idaho has a significant impact on health care issues, including insurance enrollment and health access.

Idaho's largest ethnic minority is of Hispanic heritage. Southwest, southeast and south-central Idaho in particular have large concentrations of people with Hispanic heritage. Idaho also has five Native American tribes: the Shoshone and Bannock Tribes in eastern Idaho, the Shoshone and Paiute Tribes in Duck Valley, southwestern Idaho, the Nez Perce Tribe in north central Idaho, and the Coeur d'Alene Tribe in northern Idaho.

According to the 2004 Current Population Survey, there are 384,000 children ages 18 or under in Idaho, of whom 33,000 are without health insurance. This is a significant decrease from earlier estimates of uninsured children (51,000 in 2003, 50,000 in 2002, and 45,000 in 2001). The number of children in Idaho living in families with incomes at or below 200% of the Federal Poverty Guideline (FPG) is 169,000, using a three-year average of Current Population Survey data from 2002, 2003 and 2004 (from a three-year average total of 394,000 children). Of those 169,000 children at or below 200% FPG, 30,000 are estimated to have no health insurance.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

The Idaho Department of Health and Welfare (DHW) strives to increase Idaho children's enrollment in public health insurance programs by coordinating enrollment efforts across DHW divisions, coordinating with other public agencies, and by coordinating with other stakeholders. These coordination efforts include:

- Medicaid & You—a brochure outlining the services available throughout DHW to families, including Title XIX and Title XXI child health programs.
- Idaho CareLine—an 800 number providing referral assistance to DHW customers throughout Idaho. The Idaho CareLine has a direct link to CHIP assistance. CHIP makes up the largest segment of callers on a regular basis. 888 KIDS NOW connects directly to the Idaho CareLine.
- Coordinated outreach and enrollment activities with the Idaho Department of Education and school lunch and child care food programs.
- Partnerships with stakeholder organizations that encourage posting of links to the State's CHIP website (www.chip.idaho.gov) on stakeholder web sites in order to provide current information to Idaho citizens.

In addition, DHW provides potential enrollees with several types of application assistance by:

- Providing mail-in/fax-in applications—the redesigned application allows potential CHIP enrollees to submit their application by mail or fax. Self-reliance specialists make CHIP eligibility determinations without a face-to-face visit. When information is missing, self-reliance specialists contact potentially eligible families by telephone.
- Using a simplified Application for Assistance for all benefit programs in the Self-Reliance Program (Health Coverage, Cash Assistance, Food Stamps, Child Care, Telephone Service and Nursing Home).

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Not Applicable.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The State of Idaho will use routine stakeholder meetings to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

The same method of assuring delivery of insurance products and delivery of health care services is used for Title XXI and Title XIX. Providers are required by contract to assure that services are delivered in accordance with state and federal regulations. CHIP utilizes the same provider panel as Idaho Medicaid. Providers are primarily reimbursed on a fee-for-service basis under a Primary Care Case Management (PCCM) model of managed care.

In addition, Idaho Medicaid will promote wellness by financing preventive services for children in schools. Idaho Medicaid will award grants to schools to facilitate delivery of preventive health services to low-income students. These grants will be issued as Title XXI non-primary expenditures and as an alternative to School-Based Administrative Claiming.

Existing Idaho and federal law obligates Idaho Medicaid to pay schools for covered rehabilitative and health-related services under the Individuals with Disabilities Act (IDEA). These services are listed in Individualized Education Plans (IEPs) for children identified as having special health needs. Idaho Medicaid pays schools on a fee-for-service basis by certifying school funds. In order to provide preventive services through schools, Idaho Medicaid proposes to fund services through Title XXI non-primary expenditures rather than develop an administrative claiming mechanism.

Title XXI non-primary expenditures are those program expenditures that are not medical services provided under the benefit package as described in the Title XXI state plan. Non-primary expenditures are reimbursable at the enhanced federal financial participation rate but are capped at 10 percent of the cost of benefits. Per 42 CFR 457.618, there are four categories of non-primary expenditures allowable under Title XXI, which include administrative expenditures, outreach, health initiatives and certain other child health assistance. Health Services Initiatives, defined in 42 CFR 457.10, means "activities that protect the public health, protect the

health of individuals, improve or promote a State's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children (including targeted low-income children and other low-income children)."

Initially, Idaho Medicaid will issue grants to ten (10) school districts in state fiscal year 2007 to assist schools with the salary expenses of registered nurses (RNs) working in schools or with related resource needs. Idaho Medicaid has partnered with the Idaho Department of Education and the Division of Health, Idaho Department of Health and Welfare, to establish criteria for school nurse programs eligible for Medicaid grant funding and to distribute these grants. Currently, 33 out of 114 Idaho school districts maintain school nurse programs, and Idaho schools' current RN to student ratio in Idaho is 1:2,393 (the national standard is 1:750 for the general, non-special-needs student population.) Increasing the nurse to student ratio will result in increased health counseling and education, health screenings, prevention services, health coordination, referral to care outside of school, and applications to and enrollment in Title XIX and Title XXI health coverage programs.

Grant criteria will include the percentage of low-income students and need for increased access to health services. Idaho Medicaid will fund grant amounts proportionate to percentages of low-income students in each grantee district. Idaho Medicaid will require semi-annual reports from grantee schools on provision of preventive health services and achievement of health services objectives as outlined in the grant program scope of work. Grant agreements will stipulate that grantee districts may not expend grant funds on services that may be billed through existing school-based services under a child's Individualized Education Plan.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

This State Plan uses utilization controls from the Title XIX program, including prior approval controls, peer reviews, claims processing edits, post-audit and review procedures. Primary care providers are charged with making referrals for medically necessary specialty services. Health services providers are provided a handbook describing the benefit package including limitations. Participants are issued an identification card delineating the applicable benefit package. The card is used to determine covered services and service limitations.

Section 4. Eligibility Standards and Methodology. *(Section 2102(b))*

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☒ Geographic area served by the Plan:
This State Plan applies to the entire State of Idaho.

4.1.2. ☒ Age: Children are eligible from birth through the month of the 19th birthday.

4.1.3. ☒ Income:
Children with family incomes over 133% through 185% FPL are eligible for Idaho's stand-alone SCHIP under Title XXI. Children who have family incomes over 100% through 133% FPL are eligible for Idaho's Medicaid-expansion SCHIP under Idaho's Title XIX State Plan from the month of their 6th birthday through the month of the 19th birthday.

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state):
Children served are residents of the State of Idaho.

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☒ Access to or coverage under other health coverage:
A child will be ineligible for coverage under this plan if they have access to or are enrolled in other health coverage, including the following scenarios.

- The child is covered by creditable health insurance at the time of application.
- The child has been voluntarily dropped from creditable coverage in the six months preceding application with the intention of qualifying for public coverage.
- The child is eligible under Idaho's Title XIX State Plan.
- The child is eligible to receive health insurance benefits under Idaho's state employee benefit plan

4.1.8. ☒ Duration of eligibility:

The duration of eligibility is 12 months unless the child is terminated for one of the reasons described below.

- The child loses his or her Idaho residency.
- The child attains 19 years of age.
- The child becomes eligible for and is enrolled in Medicaid.
- The child's parent or adult who is legally responsible for the child's health care makes a written request to terminate coverage.
- The application is found to have inaccurate information which effected an incorrect eligibility determination.
- The child dies.

4.1.9. ☒ Other standards (identify and describe):

- At the time of application, a) the child must not be a patient in an institution for mental diseases, or b) an inmate of a public institution.
- The Social Security number, proof of application for a Social Security number or resident alien card number must be provided for applicants who are requesting coverage. Individuals on the application that are not requesting coverage are not required to provide Social Security numbers.
- The State does not exclude individuals based on citizenship or nationality, to the extent that the child is a U.S. citizen, U.S. national or qualified alien (as defined at section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, as amended by the BBA of 1997, except to the extent that section 403 of PRWORA precludes them from receiving Federal means-tested public benefits).

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Methods of establishing eligibility and continuing enrollment include a combined application for all Idaho children's health insurance programs. The application can be mailed to DHW. Face-to-face interviews are not required. All eligibility determinations will be made within the 45 days following receipt of the application. All applicants are notified in writing regarding the outcome of their eligibility and enrollment status.

An annualized gross income figure is used to determine eligibility. There are no earned income disregards. There is no resource limit. The number of persons in the family determines the applicable income standard.

The eligibility redetermination process entails checking all available interfaces and databases for current pertinent information prior to contacting the participant by phone. If the renewal is not completed at this point, a renewal form is sent to the family at least 45 days before their health coverage will end. The form instructs the family to review the information on the form, provide any updated information, sign and return the form or call and report that there are no changes.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

The State of Idaho will ensure that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. The application for assistance requires information on when the child was last covered by health insurance. Creditable insurance determinations are made if the applicant indicates current health insurance coverage. Place of

employment is also required on the application which is used to determine if the applicant is a dependent of a State employee with access to coverage.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Through the single application process, all children are first reviewed for Title XIX eligibility. Those that are found eligible are enrolled in Title XIX. Those who are ineligible for Title XIX and meet the income standards for Title XXI are considered for Title XXI enrollment. Eligibility determinations for both Medicaid and SCHIP are handled by State employees.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The insurance provided under the state child health plan does not substitute for coverage under group health plans. A six month period of uninsurance is incorporated as an eligibility requirement for CHIP. The application requires information on when the child was last covered by health insurance. Exceptions to the period of uninsurance will be made if the applicant lost private insurance through no fault of their own (i.e., due to employer decisions) or due to hardship. The State monitors the number of eligibility denials of children that have creditable insurance who subsequently become eligible within six months.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels

become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. Indian Health Service and tribal clinics are included as CHIP service providers. Idaho Medicaid and Tribal representatives formally meet on a routine basis. Tribal representatives can request that CHIP information be presented at any of these meetings. Additionally, regional Healthy Connections Representatives (primary care case management program coordinators) work with providers and enrollees (both Medicaid and SCHIP) to resolve issues and help ensure assistance is appropriately provided.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

The State of Idaho places equal emphasis on outreach and education activities, which are those administrative procedures and program features that inform and recruit children and their families into potential enrollment. DHW directs outreach and education to the following groups.

- Health Care Providers
- Schools
- HeadStart/Child Care Providers
- Child Advocacy Groups

Idaho has developed a multi-dimensional approach to outreach including but not limited to the following.

- Support of stakeholder efforts to conduct targeted, grass-roots outreach.
- Supporting regional efforts by supplying professionally designed promotional materials.
- Provision of technical assistance to regional efforts through central office support staff.

In addition, regional outreach activities are conducted by regional Healthy Connections Representatives (primary care case management program coordinators). Healthy Connections Representatives are part of the Division of Medicaid but are located in regional offices, and coordinate outreach and education for CHIP throughout the state.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☒ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a

Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

6.2.3. ☒ Physician services (Section 2110(a)(3))

6.2.4. ☒ Surgical services (Section 2110(a)(4))

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)

(Section 2110(a)(12))

6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))
6.2.14. ☐ Home and community-based health care services (See instructions) (Section 2110(a)(14))
6.2.15. ☒ Nursing care services (See instructions) (Section 2110(a)(15))
6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)
6.2.17. ☒ Dental services (Section 2110(a)(17))
6.2.18. ☒ Inpatient substance abuse treatment services ~~and residential substance abuse treatment services~~ (Section 2110(a)(18))
6.2.19. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))
6.2.20. ☒ Case management services (Section 2110(a)(20))
6.2.21. ☒ Care coordination services (Section 2110(a)(21))
6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
6.2.23. ☒ Hospice care (Section 2110(a)(23))
6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
6.2.25. ☒ Premiums for private health care insurance coverage (Section 2110(a)(25))
6.2.26. ☒ Medical transportation (Section 2110(a)(26))
6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

The State of Idaho will provide one of two benefit packages to children eligible for Title XXI coverage. The Basic Benchmark Benefit Package is attached as Appendix 2. All other provisions of the Basic Benchmark Benefit Package are administered by the Department in accordance with statutory authority granted under Chapter 2 of Title 56, Idaho Code. The Enhanced Benchmark Benefit Package is attached as Appendix 3. All other provisions of the Enhanced Benchmark Benefit Package are administered by the Department in accordance with statutory authority granted under Chapter 2 of Title 56, Idaho Code.

To ensure that children are provided with the benefit package that will lead most directly to desired health outcomes, and to ensure that these benefits represent the most effective and efficient use of scarce health resources, Idaho Medicaid will incorporate a health risk assessment into Idaho's eligibility determination process and primary care case management (PCCM) program, Healthy Connections.

Applicants for medical assistance will complete an accompanying health questionnaire designed to assess general health status and health behaviors. The questionnaire will also serve as a screening tool to determine whether the applicant has special health needs. DHW will also assess whether the applicant requires special education services or is enrolled in Idaho's Children's Special Health Program, Infant and Toddler Program, Children's Mental Health Program or Adult Mental Health Program.

Eligibility for Idaho's Children's Mental Health Program requires a diagnosis of "serious emotional disturbance (SED). SED in children is defined in Idaho Code 16-2403(13).

Children with special health needs will be enrolled in the Enhanced Benchmark Benefit Package. Individuals without such needs will be enrolled in the Basic Benchmark Benefit Package. In addition, the questionnaire will determine whether the applicant is currently under treatment by a physician or has a medical home. If not, the applicant will receive information about Healthy Connections providers and will be asked to select a primary care provider as part of the eligibility determination process.

Failure to complete a health questionnaire will not prohibit an applicant from being determined eligible for medical assistance. However, without a completed health questionnaire, children cannot be immediately provided with the Enhanced Benchmark Benefit Package.

Subsequent to selection of a Healthy Connections provider, the participant will visit a physician for a comprehensive exam and health education. This assessment will comply with federal requirements for EPSDT for children. If the health risk assessment indicates a previously unknown special health need, the participant will be provided with the Enhanced Benchmark Benefit Package. The health risk assessment process will therefore act as both a component of eligibility determination and a safeguard to ensure that benefits address beneficiary health needs by providing access to needed services available under the appropriate benefit package.

Inpatient Hospital Services	
Basic Plan	**Enhanced Plan**
Inpatient Hospital Services include semi-private room, intensive and coronary care units, general nursing, drugs, oxygen, blood transfusions, laboratory, imaging service, physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms, routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered. No limitation is placed on the number of inpatient hospital days. However, such inpatient services must be medically necessary as determined by the Department or its authorized agent. Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment. Inpatient hospital services do not include those services provided in an institution for mental diseases. Inpatient services that are being furnished to infants and children described in 42 CFR 457.310 (targeted low income child) on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.	The same benefits as the Basic Plan with the following additional services: **Organ Transplant Procedures**. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described below. Pursuant to the provisions of applicable Department rules, the Enhanced Benchmark Benefit Package may include organ transplant services for cornea and bone marrow transplantation. Kidney, heart, intestinal, and liver transplants must be performed in Medicare certified transplant centers. The treatment of complications, consequences or repair of any medical procedure in which the original procedure was not covered, unless the resulting condition is life threatening as determined by the Department or its authorized agent is excluded from payment. Individuals qualifying under EPSDT, may receive single or double lung, or combined heart-lung transplants from Medicare certified transplant centers. All other requirements regarding the

Limitations. Payment is limited to semi-private room accommodations unless private accommodations are medically necessary and ordered by the physician. **Excluded Services.** Elective medical and surgical treatments, except family planning services and non-medically necessary cosmetic surgery, are excluded from payment unless prior approved by the Department or its authorized agent. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program are excluded from payment. Acupuncture, bio-feedback therapy, and laetrile therapy are excluded from Medicaid payment. Procedures, counseling, and testing for the inducement of fertility are excluded from Medicaid payment. Surgical procedures for the treatment of morbid obesity and panniculectomies are excluded unless prior approved by the Department or its authorized agent.	pre-authorization of hospital stays and use of Medicare certified transplant facilities will continue to apply.

Outpatient Hospital Services	
Basic Plan	**Enhanced Plan**
Outpatient Hospital Services include all benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including, but not limited to, observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; therapy services; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness. Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment. **Limitations**. ~~Visits by physical therapists and occupational therapists are limited to a total of one hundred (100) visits per recipient per calendar year.~~ Psychotherapy services are limited to forty-five (45) hours per calendar year. Services may be provided by: 1. A psychiatrist or another physician licensed by the Board of Medicine or; 2. Other licensed professionals in accordance with 42 CFR 440.60(a) including: a. Psychologist licensed by the Board of Psychologist Examiners. b. Clinical Social Worker licensed by Board of Social Work Examiners.	Same benefits as the Basic Plan.

c. Clinical Professional Counselor licensed by the Professional Counselors and Marriage and Family Therapists Licensing Board d. Marriage and Family Therapist licensed by the Professional Counselors and Marriage and Family Therapists Licensing Board e. Certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner licensed by the Board of Nursing and, at a minimum, have a master's degree. f. Licensed Professional Counselor whose provision of psychotherapy is supervised by one of those listed in 1 and 2(a-f) above and who is licensed by the Professional Counselors and Marriage and Family Therapists Licensing Board. g. Licensed Masters Social Worker whose provision of psychotherapy is supervised by one of those listed in 1 and 2(a-f) above and who is licensed by the board of Social Work Examiners. h. A Psychologist Extender, registered with the Professional Counselors and Marriage and Family Therapists Licensing Board and who is supervised by a Licensed Psychologist. Psychological evaluation, speech and hearing evaluations, physical therapy evaluation and, occupational therapy evaluation, and diagnostic services are limited to twelve (12) hours for each eligible recipient per calendar year.	

Diabetic education and training services are limited to twenty-four (24) hours of group counseling and twelve (12) hours of individual counseling through a diabetic education program or by a certified diabetic educator recognized by the American Diabetes Association. Limitations for Occupational therapy, physical therapy, and speech-language pathology services are listed under Therapy Services. Individuals qualifying under EPSDT may receive additional services if determined to be medically necessary and prior authorized by the Department.	
Emergency Services	
Basic Plan	**Enhanced Plan**
Emergency Hospital Services are covered when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in this State plan. **Limitations**. There is no limit on medically necessary emergency room services.	Same benefits as the Basic Plan.

Ambulatory Surgical Center Services (ASC)	
Basic Plan	**Enhanced Plan**
Ambulatory surgical center services are outlined in applicable Department rules and must be provided in a facility certified by Medicare as an ASC, and are restricted to those procedures identified by the Medicare program in accordance with 42 CFR 416.65, or identified by the Department as meeting such requirements.	Same benefits as the Basic Plan.
Physician Services	
Basic Plan	**Enhanced Plan**
Medical Services: These services include office, clinic, outpatient surgery center and hospital treatment by a physician for a medical condition, injury or illness. Physician services are covered whether furnished in the office, the patient's home, a hospital, or elsewhere. The Basic Plan includes treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in applicable Department rules. Medically appropriate second opinions are covered. **Limitations**. Limits on psychiatric evaluations and psychotherapy in any twelve (12) month period for Outpatient Mental Health Services shall not apply when such services are provided as Physician Services.	Same benefits as the Basic Plan.

Surgical Services: The Basic Plan includes professional services rendered by a physician, surgeon or doctor of dental surgery. **Abortions Services:** A legal abortion is only covered to save the life of the mother or in cases of rape or incest as determined by the courts. When a pregnancy is life threatening and abortion is provided to save the life of the mother, one licensed physician or osteopath must certify in writing that the woman may die if the fetus is carried to term. Cases of rape or incest must be determined by a court or documented by a report to law enforcement, except that if the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional opinion, the women was unable to report the rape or incest to law enforcement for reasons related to her health. **Excluded Services.** Hysterectomies that are not medically necessary and sterilization procedures are excluded from payment.	

Other Practitioner Services	
Basic Plan	**Enhanced Plan**
Other Practitioner Services include medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. **Certified Pediatric or Family Nurse Practitioners' Services** are those services provided by certified pediatric or family nurse practitioners as defined by state and federal law**.** This coverage has the same exclusions as Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners. Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code. **Physician Assistant Services** include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services. Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code. **Chiropractor Services** are limited to a total of twenty-four (24) office visits during any calendar year. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition.	Same benefits as the Basic Plan.

Podiatrist Services are limited to treatment of acute foot conditions. **Optometrist Services** are limited to providing eye examination and eyeglasses unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services. **Nurse-Midwife Services** are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid/CHIP agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. Certified nurse-midwife services are those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as Physician Services.	

Primary Care Case Management (PCCM)	
Basic Plan	**Enhanced Plan**
Primary Care Case Management Services are provided by a primary care case manager consistent with a program authorized under section 1937 of the Social Security Act. Most participants must enroll with a PCCM. Certain covered individuals with selected chronic diseases may enroll with a PCCM provider who receives an enhanced PCCM fee for measured clinical best practices related to chronic disease management. Enhanced PCCM fees are performance-based incentive payments made for individuals with the following chronic conditions: • Diabetes~~;~~ • ~~Asthma;~~ • ~~Cardiovascular disease;~~ ~~or~~ • ~~Depression~~.	Same benefits as the Basic Plan.
Prevention Services	
Basic Plan	**Enhanced Plan**
Health Risk Assessments. The Basic Plan includes a Health Risk Assessment which consists of: • An initial health questionnaire, and • A well child screen. The health questionnaire is designed to assess the general health status and health behaviors of a recipient. This information will be used to provide customized health education. The health questionnaire will be	Same benefits as the Basic Plan.

administered at initial program entry and periodic intervals thereafter. A well child screen conducted at periodic or interperiodic intervals which constitutes a health risk assessment will consist of a comprehensive physical examination and health education. **Well Child Screens.** Periodic medical screens completed at intervals recommended by the American Academy of Pediatrics (AAP), Committee in Practice and Ambulatory Medicine are covered. Periodic screens and Interperiodic screens should constitute a health risk assessment as specified in applicable Department rules. Interperiodic medical screens are screens that are done at intervals other than those identified in the AAP periodicity schedule referenced above and must be performed by physician or physician extender. Interperiodic screens will be performed when there are indications that is it medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screening examinations may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary.	

Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem then a developmental assessment will be ordered by the physician and conducted by qualified professionals. **Diagnostic Screening Clinics.** The Basic Benchmark Benefit Package includes services provided in a diagnostic screening clinic are outlined in applicable Department rules. **Limitations.** Service limitations for Diagnostic Screening Clinics are as follows: five (5) hours of medical social services per eligible recipient per state fiscal year is the maximum allowable. Limit of no more than five (5) hours of medical social services per recipient in each state fiscal year will be waived for EPSDT recipients. **Prevention and Health Assistance (PHA) Benefits** The Basic Plan includes certain enhanced Prevention and Health Assistance (PHA) benefits for targeted individuals provided in accordance with applicable Department rules. PHA benefits are individualized benefits to address targeted health behaviors. Authorizations will be managed by the state Medicaid agency.	

PHA benefits will be targeted to individuals who: • Use tobacco, or • Are obese. PHA benefits will be available when individuals complete specified activities in preparation for addressing the targeted health condition. These activities include discussing the condition with their primary care provider, participating in an applicable support group, and completing basic educational material related to the condition. PHA benefits may be used to purchase goods and services related to tobacco cessation and weight reduction/management in accordance with applicable Department rules. These goods and services may include nicotine patches or gum, weight-loss programs, dietary supplements, and other health related benefits. **Nutrition Services** include intensive nutritional education, counseling, and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetics Association to assure the patient's proper nutrition is allowed. Nutrition services must be discovered by the screening services and ordered by the physician; must be medically necessary; and, if over two (2) visits per year are needed, must be	

authorized by the Department prior to the delivery of additional visits. **Limitations**. Nutrition services related to obesity, including dietary assessment and individualized nutrition education, shall not be subject to the above limitations when provided as PHA benefits. **Diabetes Education and Training Clinics** provide diabetic education and training services are outlined in applicable Department rules. Outpatient diabetes education and training services will be covered under the following conditions. The education and training services are provided through a diabetic management program recognized as meeting the program standards of the American Diabetes Association. The education and training services are provided through a formal program conducted through a hospital outpatient department or a physician's office by a Certified Diabetic Educator certified by the American Diabetes Association. Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each client's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose	

monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. To receive diabetic counseling, the following conditions apply to each patient: • the patient must have a written order by his or her primary care physician or physician extender referring the patient to the program; and • the physician may not use the formally structured program or a Certified Diabetes Educator as a substitute for basic diabetic care and instruction that the physician must furnish to the patient which includes the disease process/pathophysiology of diabetes mellitus and dosage administration of oral hypoglycemic agents. The medical necessity for diabetic education and training are evidenced by the following: • a recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetic education; or, • uncontrolled diabetes manifested by two or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180	

mg/dL), in addition to manifestations, or • recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or non-healing wounds. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years **Limitations**. Diabetes education related to obesity shall not be subject to the above limitations when provided as PHA benefits.	
LABORATORY AND RADIOLOGICAL SERVICES	
Basic Plan	**Enhanced Plan**
Laboratory and Radiological Services include imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, as well as X-ray, radium or radioactive isotope therapy. Laboratory and x-ray services are provided upon and under the direction of a physician or other licensed practitioner. **Excluded Services.** Laboratory and/or x-ray procedures which are associated with excluded Hospital Services and Physician Services are excluded from payment.	Same benefits as the Basic Plan.

PRESCRIBED DRUGS	
Basic Plan	**Enhanced Plan**
Prescribed Drugs are those prescribed by a practitioner acting within the scope of his practice, chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines and prenatal vitamins. Prescribed drugs are provided for non-institutionalized persons as well as institutionalized patients. Prescriptions for oral contraceptives and diaphragms for women of child bearing age are also eligible for payment. All drug products requiring, by state or federal law, a licensed practitioner's order for dispensing or administration which are medically necessary are purchasable except for (1) those specifically excluded as ineffective or inappropriate by the Department of Health and Welfare policy, or (2) those drugs not eligible for federal participation. A prescription drug is considered medically necessary for a client if it is reasonably calculated to prevent or treat conditions in the client that endanger life, cause pain or functionally significant deformity or malfunction; and there is no other therapeutically interchangeable prescription drug available or suitable for the client requesting the service which is more conservative or substantially less costly; and the prescription drug meets professionally recognized standards of health care and is substantiated by prescriber's records including evidence of such medical necessity. Those records shall	Same benefits as the Basic Plan.

be made available to the Department upon request. The criteria used to determine medical necessity is stated in applicable Department rules. **Additional Covered Drug Products.** Additional drug products will be covered as follows: • Therapeutic Vitamins; • Injectable Vitamin B12 (cyanocobalamin and analogues); • Vitamin K and analogues; • Pediatric vitamin-fluoride preparations; • Legend prenatal vitamins for pregnant or lactating women; • Legend folic acid; • Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and • Legend Vitamin D and analogues. Prescriptions for non-legend products will be covered as follows: • Insulin; • Disposable insulin syringes and needles; • Oral iron salts; • Permethrin; and • OTC products as authorized by applicable Department rules. **Limitations**. Prior authorization will be required for certain drugs and classes of drugs. Prescribing physicians, pharmacists, and/or designated representatives may contact the Medicaid Pharmacy Unit for prior authorizations via 1-800 phone	

and fax lines, or by mail. Responses are issued within 24 hours of the request. Pharmacies are authorized to dispense a 72 hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in section 1927 (d) (5) of the Social Security Act pertaining to prior authorization programs. The following drugs require prior authorization: • Amphetamines and related CNS stimulants; • Growth hormones; • Retinoids; • Brand name drugs when acceptable generic form is available; • Medications otherwise covered by the Department for which there is a less costly, therapeutically interchangeable medication covered by the Department; • Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines; • Medications prescribed outside of the FDA approved indications; • Lipase inhibitors; and • FDA, 1-A rated single source and innovator multi-source drugs manufactured by companies not participating in the National Rebate Agreement, which have been determined by the Department to be medically necessary.	

Non-covered Drugs must be discovered as being medically necessary by the screening services for individuals qualifying under EPSDT; and must be ordered by the physician and must be authorized by the Department or its authorized agent prior to purchase of the drug. **Limitation of Quantities**. No more than a thirty-four (34) day supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription. The following medications are the only exceptions to the 34 day supply limitation. Up to one hundred (100) unit doses or a 100 day supply, whichever is less, of the following medications may be purchased: • Cardiac glycosides; • Thyroid replacement hormones; • Prenatal vitamins; • Nitroglycerin sublingual and dermal patch products; • Fluoride and vitamin fluoride combination products; and • Nonlegend oral iron salts. Oral contraceptive products may be purchased in a quantity sufficient for one (I), two (2), or three (3) cycles. **Excluded Drug Products.** • Legend drugs for which Federal Financial Participation is not available • Nonprescription items (without the Federal Legend), except	

permethrin, oral iron salts, disposable insulin syringes and needles, and OTC products as authorized by applicable Department rules. • Ovulation stimulants and fertility enhancing drugs. • Medications used for cosmetic purposes. • Prescription vitamins except injectable B12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid. Nicotine cessation products, diet supplements and weight loss products are excluded unless provided as PHA benefits.	
Family Planning Services	
Basic Plan	**Enhanced Plan**
Family Planning Services include pre-pregnancy family planning services and prescribed supplies including birth control contraceptives. Family planning services and supplies for individuals of child-bearing age include counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Department will cover diagnosis, treatment, contraceptive supplies, and related counseling. The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and	Same benefits as the Basic Plan.

conscience, and freedom of choice of method to be used for family planning. All requirements of 42 CFR Part 441, Subpart F are met. **Limitations**. **Contraceptive supplies** include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply. Hysterectomies performed solely for sterilization are ineligible for payment.	
Mental Health Services	
Basic Plan	**Enhanced Plan**
Inpatient Psychiatric Services includes services for Certain Individuals in Institutions for Mental Diseases. **Inpatient psychiatric facility services** include services provided which meet medical necessity criteria determined by the Department or its authorized agent and provided in a JCAHO accredited hospital. **Limitations**. Inpatient mental health services, including Psychiatric Services covered under Inpatient Hospital Services, are limited to ten (10) days per calendar year. **Outpatient Mental Health Services** includes Clinic Services and other Rehabilitative Services.	**Inpatient Psychiatric Services** Same benefits as the Basic Plan but not subject to the limitations of the Basic Plan. **Outpatient Mental Health Services** includes Clinic Services and other Rehabilitative Services. **Mental Health Clinics.** Clinic services are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician. Services provided in a mental health clinic are outlined in applicable Department rules. **Limitations.** **Psychotherapy Services.** As set forth in applicable Department rules are limited to forty-five (45) hours per calendar year.

Mental Health Clinics. Clinic services are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician. Services provided in a mental health clinic are outlined in applicable Department rules. **Limitations.** **Psychotherapy Services** are limited to twenty-six (26) visits per calendar year. **Evaluation and Diagnostic Services**. Any combination of any evaluative or diagnostic services and care plan development is included in the limit of twenty-six (26) visits per calendar year. **Excluded Services.** • ~~Partial care treatment, and~~ • Psychosocial rehabilitation.	**Evaluation and Diagnostic Services.** ~~A combination of any~~ Evaluative ~~or~~ and diagnostic services ~~and care plan development is~~ are limited to ~~twelve (12)~~ four (4) hours for each eligible recipient per calendar year. Care plan development is limited to two (2) hours per calendar year. Psychological and neuropsychological testing is limited to two (2) computerized testing sessions and four (4) assessment hours per calendar year. ~~Individuals qualifying under EPSDT, may receive evaluative and diagnostic services in excess of the twelve (12) hours per calendar year limit.~~ ~~**Partial Care Services.** Partial care treatment will be limited to thirty-six (36)~~ twelve (12) ~~hours per week, per eligible recipient.~~ ~~Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive partial care treatment in excess of the thirty-six (36)~~ twelve (12) ~~hours per week limit.~~ **Psychosocial Rehabilitative Services (PSR)** includes services provided to reduce to a minimum a participant's mental disability and restore the participant to the highest possible functional level within the community. These services are outlined in applicable Department rules.

	Limitations. • ~~A combination of any~~ Evaluation and~~or~~ diagnostic services ~~is~~ are limited to a maximum of ~~six (6)~~ four (4) hours in a calendar year. • Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours in a calendar year. • Community crisis support services are limited to ten (10) hours ~~a maximum of~~ over seven (7) ~~five (5)~~ consecutive days and must receive prior authorization from the ~~Division of Family and Community Services~~ Department. Individual and group psychosocial rehabilitation services are limited to ~~twenty~~ ~~ten~~ five hours (~~2~~10 ~~5~~) per week and must receive prior authorization from the ~~Division of Family and Community Services~~Department. ~~Services in excess of twenty (20) hours require additional review and prior authorization by the Department.~~ This limitation includes any psychosocial rehabilitation services provided in crisis situations and post psychiatric hospitalization. Individuals qualifying under EPSDT, may receive services in excess of limitations. **Excluded services.** Treatment services rendered to recipients residing in inpatient medical

	facilities including nursing facilities or hospitals, ~~is~~ are excluded. Recreational therapy, which includes activities which are primarily social or recreational in nature, is excluded. Job-specific interventions, job training and job placement services which includes helping the recipient develop a resume, applying for a job, and job coaching, is excluded. Staff performance of household tasks and chores, is excluded. Client staffing within the same PSR agency, is excluded. Services for the treatment of other individuals, such as family members, is excluded Any other services not listed in applicable Department rules, are excluded.
Home Health Care	
Basic Plan	**Enhanced Plan**
Home Health Care Services include intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area. Services also include home health aide services provided by a home health agency. Home health services are provided in accordance with the requirements of	The same benefits as the Basic Plan with the following additional services: **Private Duty Nursing (PDN)** are nursing services provided by a licensed professional nurse or licensed practical nurse to a non-institutionalized child requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. The nursing needs must of such a nature that the Idaho Nursing Practice Act, Rules, Regulations, or

42 CFR 441.15. **Limitations**. Services by a licensed nurse, when no home health agency exists in the area, must be prior approved by the Department as defined in 42 CFR 440.70(b)(l). Home health visits are limited to one hundred (100) per recipient per calendar year provided by any combination of home health agency licensed nurse, home health aide, home health physical therapist, home health occupational therapist, home health speech-language pathologist, or licensed nurse. Individuals qualifying under EPSDT, may receive in excess of one-hundred (100) visits per calendar year ~~limit. these limited visits per calendar year~~ when the services are prior authorized by the Department.	Policy require the service to be provided by an Idaho Licensed Professional Nurse (RN), or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from Home Health nursing services. PDN Services must be ordered by a physician, and include: 1. A function which cannot be delegated to an Unlicensed Assistive Personnel (UAP) as defined by Idaho Code and Administrative Rules of the Idaho State Board of Nursing. 2. An assessment by a licensed professional nurse of a child's health status for unstable chronic conditions, which includes: • A medical status that is so complex or unstable, as determined by the attending physician, that licensed or professional nursing assessment is needed to determine the need for changes in medication or other interventions; or • A licensed or professional nursing assessment to evaluate the child's responses to interventions or medications. Services delivered must be in a written plan of care, and the plan of care must be developed by a multi-disciplinary team. The plan of care must be revised and updated as the child's needs change or

	upon significant change of the condition, but at least annually, and must be submitted to the Department or its authorized agent for review and prior authorization of service. **Limitations**. PDN services must be authorized by the Department or its authorized agent to delivery of service. PDN Services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. However, if service is requested only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences: • Licensed Nursing Facilities (NF); • Licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR); • Licensed Residential Care Facilities; • Licensed hospitals; and • Public or private school
Therapy Services	
Basic Plan	**Enhanced Plan**
Therapy Services include physical therapy, occupational therapy, ~~or~~ and speech-language pathology ~~and audiology~~ services provided by a home health agency, independent therapy provider, hospital outpatient facility, or medical rehabilitation facility.	Same benefits as the Basic Plan.

~~**Physical therapy services** may be furnished by a licensed physical therapist as defined under 42 CFR 440.110 by direct order of a physician~~ **Therapy services** by an independent provider may be furnished by the following providers: • Physical therapist who in accordance with 42 CFR 440.110(a) is licensed by the PT Licensing Board within the Board of Occupational Licensing. • Occupational Therapist who in accordance with 42 CFR 440.110(b) is licensed by the Board of Medicine. • Speech-Language Pathologist who in accordance with 42 CFR 440.110(c), is licensed by the Speech and Hearing Services Licensure Board within the Board of Occupational Licensing. All therapy services are provided according to a written physician order as a part of a plan of care, and be provided either in the patient's home or in the therapist's office. An office in a nursing home or hospital is not considered an independent therapist's office. **Respiratory care services** may be furnished to individuals qualifying under EPSDT. **Limitations**. ~~Recipients are limited to twenty-five (25) visits per calendar year without prior authorization by the Department. Included in this limitation are outpatient~~	

~~hospital, independent providers, and physical therapy under school-based services and developmental disability agencies.~~ ~~Home health agency visits by physical therapists and occupational therapists are limited to a total of one-hundred (100) visits per recipient per calendar year. Included in the total visit are all home health aides, nursing services, physical therapy services, and occupational therapy services in any combination. Speech pathology and audiology services are not provided for under home health services.~~ Unless additional services are prior authorized, participants are limited to: • Twenty-five (25) physical therapy visits per calendar year • Twenty-five (25) occupational therapy visits per calendar year • Forty (40) speech-language pathology visits per calendar year Included in this limitation are outpatient hospital facilities, independent providers, outpatient rehabilitation facilities, and developmental disability agencies. Home health agency visits by home health aides, nursing services, physical therapists, occupational therapists, and speech-language pathologists in any combination are limited to a total of one-hundred (100) visits per participant per calendar year. Individuals qualifying under EPSDT, may receive additional services if determined to be medically necessary	

and prior authorized by the Department.	
~~SPEECH, HEARING AND LANGUAGE~~ AUDIOLOGY SERVICES	
Basic Plan	**Enhanced Plan**
Audiology Services include services for individuals with ~~speech,~~ hearing~~, and language~~ disorders provided by ~~or under the supervision of a speech pathologist or~~ an audiologist who is licensed by the Speech and Hearing Services Licensure Board in accordance with 42 CFR 440.110(c). Individuals qualifying under EPSDT, may receive services in addition to those listed in this section (Audiology services), if those services are determined to be medically necessary and prior authorized by the Department. **Audiology Services** include audiometric services and supplies according to applicable Department rules. The Department will cover hearing screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens; the hearing screen is considered part of the medical screening service. **Hearing Aids.** Hearing aids and related services will be covered by the Department. **Augmentative Communication Devices**. Augmentative communication devices are covered as	Same benefits as the Basic Plan.

specified in applicable Department rules. Individuals qualifying under EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department. **Limitations**. The Department will pay for one audiometric examination and testing related to the exam each calendar year when ordered by a physician and provided by a certified audiologist and/or licensed physician. Any hearing test beyond the basic comprehensive audiometry and independent testing must be ordered in writing before the testing is done. The Department will purchase one (1) hearing aid per recipient with prior approval of the Department. Follow up services are included in the purchase of the hearing aid for the first year. Necessary repairs resulting from normal use after the second year will be covered. Hearing aid batteries will be purchased on a monthly basis. Refitting of hearing aid or additional ear molds will be purchased no more often than forty-eight (48) months from the last fitting. Individuals qualifying under EPSDT, may receive audiology services and supplies ordered by a licensed physician and supplied by a physician or certified audiologist, with the following exceptions:	

• When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted; or • Replacement hearing aids may be authorized if the requirements in applicable Department rules are met. The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist.	
Medical Equipment, Supplies And Devices	
Basic Plan	**Enhanced Plan**
Medical Equipment and Supplies includes durable medical equipment and other medically-related or remedial devices. These also include medical supplies, equipment, and appliances suitable for use in the home. Medical equipment and medical supplies must be ordered in writing by a physician. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual. **Limitations**. Items not specifically listed in applicable Department rules will require	Same benefits as the Basic Plan.

prior authorization by the Department or its authorized agent. **Specialized Medical Equipment and Supplies** **Oxygen and related equipment** is covered for individuals qualifying under EPSDT when the medical need is discovered during a screening service and is physician ordered. PRN oxygen, or oxygen as needed on less than a continual basis, will be authorized for six (6) months following receipt if medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration, and an estimate of the frequency and duration of use. Portable oxygen systems may be ordered to compliment a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. Laboratory evidence for hypoxemia is not required under the age of six (6) months. **Prosthetic Devices** These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics. The Department will purchase and/or	

repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body. **Limitations**. Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent. Limit of one refitting, repair or additional parts in a calendar year. Individuals qualifying under EPSDT, may receive more than one refitting, repair or additional parts in a calendar year.	
Vision Services	
Basic Plan	**Enhanced Plan**
Vision Services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist. The Department will pay for vision services and supplies. One eye exam by physicians and/or optometrists is allowed during any twelve (12) month period. The Department will cover vision-screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens; the vision is considered part of the medical screening service, (i.e. eye chart). The Department will pay for one (1) eye examination by an ophthalmologist or	Same benefits as the Basic Plan.

optometrist during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct or treat refractive error. **Eyeglasses.** Each recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive one (1) pair of eyeglasses per year, except in the following circumstances: In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change; or the Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less that the cost of new frames. If repair costs are greater than the cost of new frames, new frames may be authorized. Lenses will be provided when there is documentation that the correction needed is equal to or greater than plus or minus one-half (.50) diopters of correction. **Limitations**. ~~Polycarbonate lenses will be purchased only when it is documented that the prescription is above plus or minus two (2.00) diopters of correction.~~ Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department. Contact lenses will be	

covered only when documentation of an extreme myopic condition requiring a correction equal or greater than minus ~~four (-4)~~ ten (-10) diopters, cataract surgery, keratoconus, anisometropia or other extreme medical condition preclude the use of conventional lenses. Replacement lenses will be purchased only when there is documentation of a major visual change of at least one-half (.50) diopter plus or minus.	
~~Dental Services~~	
~~Basic Plan~~	**~~Enhanced Plan~~**
~~**Medical and Surgical Services** are covered for treatment of medical and surgical dental conditions when furnished by a licensed dentist subject to the limitations of practice imposed by state law, and according to applicable Department rules.~~ ~~**Dentures** are covered as specified in applicable Department rules.~~ ~~**Limitations**.~~ ~~Elective medical and surgical dental services are excluded from payment unless prior approved by the Department or its authorized agent. All hospitalizations for dental care must be prior approved by the Department or its authorized agent.~~ ~~**Excluded Services**.~~ ~~Non-medically necessary cosmetic services are excluded from payment. Drugs supplied to patients for self-administration other than those allowed by applicable Department rules are~~	~~Same benefits as the Basic Plan.~~

~~excluded from payment.~~ ~~**Other Dental Care** includes professional dental services are provided by a licensed dentist or denturist as described in applicable Department rules. The Department will cover dental services including diagnostic, preventative, restorative treatment, endodontics, periodontics, fixed and removable prosthodontics, maxillofacial prosthetics, oral surgery, orthodontics and adjunctive general services.~~	
Essential Providers	
Basic Plan	**Enhanced Plan**
Clinic Services and Rehabilitative Services are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician and which may include those services provided by community health centers. **Rural Health Clinic** services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan. **Federally Qualified Health Center (FQHC**) services and other ambulatory services that are furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4). **Indian Health Service Facility** services are provided in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers. **Independent School Districts** which	Same benefits as the Basic Plan.

have entered into a provider agreement with the Department ~~provide rehabilitative services which are the core medical rehabilitative services to be provided on a statewide basis. Services provided by Independent School Districts are outlined in the applicable Department rules.~~ may bill for the following services when they are identified on the student's Individual Education Plan (IEP). All provider qualification and prior authorization requirements as specified in IDAPA 16.03.09 for these services apply. ~~**Covered Services:**~~ **Collateral Contact –** ~~Consultation or treatment direction about the student to a significant other in the student's life. Collateral contact may not be reimbursed for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings.~~ **Developmental Therapy–** Instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training and therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability. **Medical Equipment and Supplies –** Medical equipment and supplies that are covered by Medicaid and are needed for use at school but are too	

large or unsanitary to transport from home to school. They must be for the student's exclusive use and transfer with the student if the student changes schools. **Nursing Services –** Skilled nursing services that must be provided by a licensed nurse. Emergency, first aide or assistance with non-routine medications not identified on the IEP as health related services are not reimbursable. **Occupational Therapy and Evaluation –** Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation is not covered. **Personal Care Services –** School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements while at school. **Physical Therapy and Evaluation** **Psychological Evaluation** **Psychotherapy** **Psychosocial Rehabilitation and Evaluation –** Services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills, and coping skills. **Intensive Behavioral Intervention –** Short term, one-on-one comprehensive interventions that produce measurable	

outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills. **Speech/Audiological Therapy and Evaluation** **Social History and Evaluation** **Transportation –** Student must require special transportation that is ordered by a physician and included on the IEP, and receive another Medicaid reimbursable service on the same day. **Interpretive Services –** May only be billed when the student needs the services of an interpreter to receive a Medicaid reimbursable service. Not covered if the person providing the service is able to communicate in the student's primary language. **Limitations**. ~~The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.~~ ~~Evaluation and diagnostic services are limited to twelve (12) hours in any calendar year.~~ ~~Psychotherapy services are limited to a maximum of forty-five (45) hours per calendar year.~~ ~~Speech and hearing services are limited to two hundred and fifty (250) treatment sessions per calendar year.~~ ~~Physical therapy services are limited to~~	

~~one hundred (100) treatment sessions per calendar year.~~ ~~Developmental and occupational therapy services are limited to thirty (30) hours per week.~~ ~~Individual Education Plan (IEP) development services (Independent School district providers only) are limited to one (1) per year.~~ School Districts are subject to the limitations for covered services. Services provided by schools do not count towards the limitations on covered services for other service providers. Services beyond the scope of service limitation must be identified in an EPSDT screen, found to be medically necessary, and prior authorized. **Excluded Services**. ~~The following services are excluded from the Basic Benchmark Benefit Package covered under the State plan.~~ ~~Vocational services are excluded.~~ ~~Educational services are excluded.~~ ~~Recreational services are excluded.~~ Vocational, Educational and Recreational services are not reimbursable.	
Medical Transportation Services	
Basic Plan	**Enhanced Plan**
Medical Transportation Services include transportation services and assistance for eligible persons to medical facilities. Payment for meals	Same benefits as the Basic Plan.

and lodging may be authorized where appropriate. Ambulance services will be covered in emergency situations or when prior authorized by the Department or its designee. **Limitations**. Requests for transportation services will be reviewed and authorized by the Department or its designee. Authorization is required prior to the use of transportation services except when the service is emergent in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs. **Excluded Services**. Transportation to medical facilities for the performance of medical services or procedures which are excluded from payment are also excluded.	
Long Term Care Services	
Basic Plan	**Enhanced Plan**
Not covered under Basic Plan.	**Personal Care Services** are services furnished to a participant who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are: • provided in accordance with a plan of care; • provided by an individual who is qualified to provide such services and who is not a member of the individual's

	family; and • provided in the participant's home. Providers who are expected to carry out training programs for developmentally disabled participants must be supervised at least every ninety (90) days by a Qualifed Mental Retardation Professional (42 CFR 483.430(a)). **Limitations**. Services are limited to sixteen (16) hours per calendar week, per eligible client. Individuals qualifying under EPSDT, may receive personal care services in excess of sixteen hours of service per week.
Hospice Care	
Basic Plan	**Enhanced Plan**
Not covered under Basic Plan.	**Hospice Care** is provided only to terminally ill recipients when furnished by a Medicare certified hospice. **Limitations**. A recipient is provided up to eight calendar months of hospice care. The benefit period starts on the first day of the month in which hospice was elected and hospice is automatically renewed each month until the date of the recipient's death, revocation, or failure to meet monthly eligibility requirements. The recipient will have at least 210 hospice days available. Respite days are limited to five days

	per benefit period (calendar month).
Developmental Disability Services	
Basic Plan	**Enhanced Plan**
Not covered under Basic Plan.	**Developmental Disability Agency Services** includes rehabilitative services which are the core medical rehabilitative services to be provided on a statewide basis by facilities which have entered into a provider agreement with the Department and are licensed as Developmental Disability Agencies (DDAs) by the Department. Services provided by DDAs are outlined in the applicable Department rules. **Intensive Behavioral Interventions (IBI)** are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. IBI is available only to children who have self-injurious, aggressive, or severely maladaptive behavior and severe deficits in the areas of verbal and non-verbal communication; or social interaction; or leisure and play skills. IBI is available in a developmental disability agency, Idaho public school districts or other public educational agencies. IBI services cannot exceed ~~thirty (30)~~ twenty-two (22) hours per week in combination with developmental therapy and occupational therapy in a developmental disability agency. IBI

	services are limited to a three (3) year duration in developmental disability agencies, and Idaho public school districts or other public educational agencies. After three (3) years the expectation is that these clients will be reassessed and transitioned into appropriate services. A professional qualified to provide or direct the provision of Intensive Behavioral Intervention must have Department approved training and certification which addresses course work, experience, ethical standards, continuing education and demonstrated competencies and: • have at least a bachelor's degree in psychology, special education, social work, applied behavior analysis, speech and language pathology, occupational therapy, physical therapy, deaf education, elementary education or a related field; or • be a Licensed Professional Counselor. **Limitations**. ~~Rehabilitative~~ Evaluation and Diagnostic services provided by Developmental Disabilities Agencies are limited to ~~twelve (12)~~ four (4) hours reimbursable time allowed for the combination of all evaluations or diagnostic services. Psychological testing by a DDA is limited to two (2) computerized testing sessions and four (4) assessment hours per calendar year.

	Therapies are limited to twenty-two (22) hours per week. Individuals qualifying under EPSDT may receive services in excess of the limits. ~~the limit of two-hundred (200) treatment sessions per calendar year of speech and hearing therapy; limit of maximum of thirty (30) hours per week of developmental and occupational therapy will be waived for EPSDT recipients.~~
Special Services For Children/EPSDT	
Basic Plan	**Enhanced Plan**
EPSDT Services include diagnosis and treatment involving medical care as well as such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in this State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSDT. Needs for services discovered during a screening which are outside the coverage provided by applicable Department rules must be shown to be medically necessary and the least costly means of meeting the recipient's medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant.	Same benefits as the Basic Plan.

The Department will not cover services for cosmetic, convenience or comfort reasons. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in applicable Department rules specifically as a covered benefit or service will require preauthorization for medical necessity prior to payment for that service. Any service required as a result of a screen and which is currently covered under the scope of the Basic Plan will be provided to individuals without regard to amount, scope, and duration limitations, but will be subject to prior-authorization. The additional service must be documented by the attending physician as medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department or its authorized agent will be required prior to payment. Those services required as a result of a screen and which are currently covered under the scope of the Basic Benchmark Benefit Package will provided under an Enhanced Benchmark Benefit Package, or as wrap-around services to benefits covered under the State plan for children who do not opt-in to an Enhanced Plan.	
Case Management Services	
Basic Plan	**Enhanced Plan**
Not covered under Basic Plan.	**Case Management Services** are provided to targeted children who meet the requirements set forth in Department rules. A Service Plan must be completed and authorized prior to delivery of case management

	services. The case manager must review and update the approved service plan for service coordination at least annually. The Department or its authorized agent must approve the Service Plan for continued authorization.
Specific Pregnancy-Related Services	
Basic Plan	**Enhanced Plan**
Risk Reduction Follow-up. Services to assist the client in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. Payment is available to licensed social workers, registered nurses and physician extenders either in independent practice or as employees of entities which have current provider agreements with the Department. **Individual and Family Medical Social Services.** Services directed at helping a patient to overcome social or behavioral problems which may adversely affect the outcome. Payment is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Board of Social Work Examiners. **Nutrition Services.** Intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally	Same benefits as the Basic Plan.

accredited college or university and has met the academic/profession requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment for two (2) visits per pregnancy is available. **Nursing Services**. Home visits by a registered nurse to assess the client's living situation and provide appropriate education and referral during the covered period. A maximum of two (2) visits per pregnancy is provided. **Maternity Nursing Visit.** Office visits by a registered nurse, acting within the limits of the Nurses Practices Art, for the purpose of checking the progress of the pregnancy. These services must be prior authorized by the Department's care coordinator and can be paid only for women unable to obtain a physician to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. **Qualified Provider Risk Assessment and Plan of Care.** When prior authorized by the Department care coordinator, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care.	
Substance Abuse Treatment Services	

Basic Plan	Enhanced Plan
Substance Abuse Treatment Services are provided to individuals screened eligible for such services in accordance with applicable Department rules. **Covered Services:** Assessment: maximum of eight (8) hours per year- includes annual assessment, interviewing and treatment plan building. Each individualized treatment plan is based on a biopsychosocial assessment of the participant's alcohol or substance abuse treatment needs. This assessment must be conducted utilizing a Department-approved standardized assessment tool. Drug screening: maximum of three (3) per week. Urinalysis to detect the presence of alcohol or drugs. Individual counseling: maximum of twelve (12) hours per week. Service provided to a participant in a one-on-one setting (one participant and one counselor). The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both. Group counseling: maximum of twelve (12) hours per week. Service provided to participants in a peer group setting. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both.	Same benefits as the Basic Plan.

Service coordination: maximum of four (4) hours per week and fifty five (55) hours per year. Service coordination consists of: • Finding, arranging and assisting the participant to gain access to and maintenance of services, supports and community resources • Monitoring participant progress- includes verifying that services are received and are satisfactory to the participant, ascertaining that services meet the participant's needs, documenting progress and any revisions in services needed, and making alternative arrangements if services become unavailable to the participant. • Planning- community reintegration planning and exit planning Service coordination is provided on an outpatient basis to participants who are at risk of being institutionalized. Family therapy: maximum of two (2) hours per week. Service provided jointly to a participant and the participant's family. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both. Family therapy sessions are for the exclusive benefit of the participant. Assessment: must be conducted by an individual who is:	

• Certified in administering the standardized assessment tool being utilized. And, who has one thousand forty (1,040) hours of supervised experience providing substance abuse treatment and meets one (1) of the following criteria: • Alcohol and drug counselor certified by the Idaho Board of Alcohol/Drug Counselor's Certification, Inc. (CADC or Advanced CADC). • Licensed professional counselor or Licensed clinical professional counselor. Licensed physician. • Licensed psychologist. • Licensed physician assistant, nurse practitioner or clinical nurse specialist. • Licensed clinical or licensed masters social worker. • Licensed marriage and family therapist. • Licensed associate marriage and family therapist. Drug screening: urinalysis must be conducted in a laboratory that is under the direction of a physician or other licensed provider. Therapy and counseling services and Service Coordination must be provided by an individual who has one thousand forty (1,040) hours of supervised experience providing substance abuse treatment and meets one (1) of the following criteria: • Alcohol and drug counselor certified by the Idaho Board of	

Alcohol/Drug Counselor's Certification, Inc. (CADC or Advanced CADC). • Licensed professional counselor or Licensed clinical professional counselor. • Licensed physician. • Licensed psychologist. • Licensed physician assistant, nurse practitioner or clinical nurse specialist. • Licensed clinical or licensed masters social worker. • Licensed marriage and family therapist. • Licensed associate marriage and family therapist.	

6.2.-D The State will provide dental coverage to children through one of the following. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1.-D ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:
1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.2-D ☒ Periodicity Schedule. The State has adopted the following periodicity schedule:
☒ State-developed Medicaid-specific
☐ American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity schedule
☐ Other (description attached)

6.2.2-D ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1.-D ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)

6.2.2.2-D ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses

to provide supplemental services, please also attach a description of the services and applicable CDT codes)

6.2.2.3.-D ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by

the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Claims data are collected and analyzed to assess performance using National Performance Measurements (see section 9.3.6). An annual participant survey monitors and assesses quality and appropriateness of care.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards
7.1.2. ☐ Performance measurement
7.1.3. ☐ Information strategies
7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

Enrollment in Idaho's primary care case management program (Healthy Connections) is required in most areas of the state, which helps to ensure that enrollees have a usual source of care. Primary care providers are required by contract to provide primary care services to their enrollees. This includes wellness care and immunizations. In addition, Healthy Connections Representatives (primary care case management program coordinators) work with enrollees and providers to help ensure appropriate covered services are provided.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

The State of Idaho will ensure access to covered services, including emergency services as defined in 42 CFR 457.10. Referrals are not required

to access emergency services. All provider types necessary to provide covered services are included in the provider panel.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

The State of Idaho will ensure access to appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition.

Contractually, primary care providers are required to make referrals for most medically necessary specialty services. All provider types necessary to provide covered services are included in the provider panel. In addition, Healthy Connections Representatives (primary care case management program coordinators) work with enrollees and providers to help ensure appropriate covered services are provided.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

Decisions related to prior authorization of health services will be completed in accordance with State law and/or Administrative Rule and the medical needs of the patient.

Section 8. Cost Sharing and Payment *(Section 2103(e))*

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. ☒ YES
8.1.2. ☐ NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

Enrollees in the Basic Benchmark Benefit Package with family incomes at or above 150% FPL will be subject to a premium in the amount of $10 per member per month for medical services and an additional $5 per member per month for dental services. Premium amounts paid apply first to medical services in determining delinquency. Enrollees in the Basic Benchmark Benefit Package with family incomes above 133% FPL up to 150% FPL will be subject to a premium in the amount of $10 per member per month for medical services and are not subject to the dental premium. Delinquent payments must be paid before re-enrollment (see Section 8.7 for further delinquency and disenrollment protection information). Enrollees in the Enhanced Benchmark Benefit Package are not subject to premiums.

Wellness Preventive Health Assistance (PHA): The state has established a mechanism to assist participants with their premium payment obligations. This mechanism is called Wellness PHA. Each participant who is required to make premium payments can earn 30 points every 3 months by receiving recommended wellness visits from their PCP and demonstrating up-to-date immunizations. These Wellness PHA points can be used to offset premium payments. Each point equals one dollar.

A child with family income below 150% FPG may have all his premium obligations met by utilizing Wellness PHA. Children in families 150-185% FPG may offset up to two-thirds (two out of every three) of their

payments.

8.2.2. Deductibles: Not applicable

8.2.3. Coinsurance or copayments:

A participant who seeks care at a hospital emergency department for a condition that is not an emergency medical condition may be required to pay a co-payment to the provider. The determination that the participant does not have an emergency medical condition is made by the emergency room physician conducting the medical screening and using the prudent layperson standard.

A participant who accesses emergency transportation services for a condition that is not an emergency medical condition may be required to pay a co-payment to the provider of the service. The determination that the participant did not have an emergency medical condition is made by Idaho Medicaid.

Beginning on February 1, 2007, the nominal fee amount required to be paid by the participant as a co-payment is three dollars ($3.00). This nominal amount will be adjusted annually as determined by the Secretary of Health and Human Services.

8.2.4. Other: Not applicable

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(B)) (42CFR 457.505(b))

Changes to cost-sharing requirements are communicated through the public legislative process. DHW also adheres to a public rules promulgation process in order to communicate cost-sharing and other program changes.

In addition, the public is made aware of cost-sharing requirements through the following communication methods.

- Publication on the State's Medicaid website.
- Program information materials including brochures and applications.
- Program notices to participants at eligibility determination and redetermination.
- Public hearings held in conjunction with Administrative rules promulgation.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The State of Idaho will ensure that the annual aggregate cost-sharing for a family does not exceed five (5) percent of such family's income for the length of the child's eligibility period in the State. Upon enrollment participants are sent a notice advising them of their cost-sharing responsibilities. This includes notice of the five percent maximum.

Cost-sharing in the Idaho plan is set so low that very few families will reach their 5% limit. Additionally, a family that does exceed the limit will do so due to inappropriate use of emergency services.

Through the various information strategies such as the use of eligibility workers and other avenues of information dissemination, participants and their families are informed as to the limits of their financial liability for the coverage. The first direct written communication with families instructs parents that the expenditures on their child(ren)s health care should not exceed 5% of family income.

Benefit booklets are provided to all participants at initial eligibility determination and upon request thereafter. Information is included which directs families to inform the state whenever the 5% maximum is met or exceeded.

The State has adopted the "shoe box" approach to reimburse families who exceed the 5% limit. Families are required to track expenditures based on he calculation of

family income provided by the state and to submit receipts for all expenditures in excess of the 5% limit. The family will receive a refund in an amount equal to their excess payments.

Once the maximum out of pocket is met, the family is not required to pay premiums for the remainder of the eligibility period.

8.6. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

The state will ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. Native American and Alaskan Native children will not be charged monthly premiums or co-payments. The family will be required to declare tribal membership so that the cost sharing exemption can be processed.

8.7. Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Renewal: If premium payments are two or more months in arrears at the time of renewal, the child(ren) will lose eligibility for the program and be prohibited from participation until the delinquency is paid. Delinquent accounts will be sent a delinquency notice monthly. The notice includes the amount of the delinquency, their right to be considered for Medicaid eligibility and the consequence of not bringing their account current. The notice also includes a reminder that the family may receive help with their premium payments by participating in Wellness PHA.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing

category as appropriate. (42CFR 457.570(b))

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

The state of Idaho has developed a set of strategic objectives, performance goals, and performance measures to assess the success of implementing its Children's Health Insurance Program. Idaho will track enrollment, retention, access, comprehensiveness, and quality of care. All performance measures will be linked to performance standards and strategic objectives. These measures are designed to measure the effectiveness of both Title XIX and Title XXI Programs. The objectives, goals, and measures focus on standard indicators of success in enrollment and retention and in basic health outcomes. The measures have been developed based upon data that is readily available to the Department of Health and Welfare.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

<table>
<tr><th colspan="3">Table 9.1</th></tr>
<tr><th>(1) Strategic Objectives</th><th>(2) Performance Goals for each Strategic Objective</th><th>(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)</th></tr>
<tr><td colspan="3">Objectives related to Reducing the Number of Uninsured Children</td></tr>
<tr><td rowspan="3">To increase the number of children participating in Title XIX and XXI health programs.</td><td rowspan="3">The targeted increase in enrollment is 8,000 children annually</td><td>New/Revised Continuing X</td></tr>
<tr><td>Data Sources: Enrollment data from the Division of Medicaid AIM system.</td></tr>
<tr><td>• Methodology: Annual increase in enrollment of uninsured children in both programs compared to the previous federal fiscal year.
• The total number of new uninsured children enrolled in both programs compared to the base number of enrollees as of 9/30/99
• Numerator: Number of enrollees on 9/30/03: 112,678
• Denominator: Number of enrollees on 9/30/99: 54,824</td></tr>
</table>

<table>
<tr><th colspan="3">Table 9.1</th></tr>
<tr><th>(1) Strategic Objectives</th><th>(2) Performance Goals for each Strategic Objective</th><th>(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)</th></tr>
<tr><td></td><td></td><td>Progress Summary: Idaho achieved its annual target by increasing enrollment an additional 8001 children in FFY03. As of 9/30/03, Idaho has enrolled an additional 57,854 children, more than doubling the number of children covered by Title XIX & Title XXI in the past 4 years.</td></tr>
<tr><td colspan="3">Objectives Related to SCHIP Enrollment</td></tr>
<tr><td rowspan="4">To increase the number of children enrolled in the Title XXI. program</td><td rowspan="4">The targeted increase in enrollment is 2,000 children annually.</td><td>New/Revised Continuing X</td></tr>
<tr><td>Data Sources: Enrollment data from the Division of Medicaid AIM system</td></tr>
<tr><td>• Methodology: Annual increase in enrollment of uninsured children compared to the previous federal fiscal year.
• The total number of children enrolled each year.
• Numerator: Number of enrollees on 9/30/03: 10,954
• Denominator: Number of enrollees on 9/30/99: 3,735</td></tr>
<tr><td>Progress Summary: The number of Title XXI children decreased this year for the first time in 4 years. The number decreased by 1,022 in FFY03 resulting in an 8.5% decline. It is believed that with the downturn in the economy, children applying for assistance are qualifying for Title XIX instead of Title XXI. The statistics bear this out. As of 9/30/03, overall Idaho had increased enrollment since 1999 by 7,219 children, a 193% increase.</td></tr>
<tr><td colspan="3">Objectives Related to Increasing Medicaid Enrollment</td></tr>
<tr><td rowspan="2">To increase the number of children enrolled in Title XIX health</td><td rowspan="2">The targeted increase in enrollment is 6,000 children annually.</td><td>New/Revised Continuing X</td></tr>
<tr><td>Data Sources: Enrollment data from the Division of Medicaid AIM system.</td></tr>
</table>

Table 9.1		
(1) Strategic Objectives	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)**
programs		• Methodology: Annual increase in enrollment of uninsured children in Title XIX programs compared to the previous federal fiscal year. • The total number of new uninsured children enrolled in Title XIX programs compared to the base number of enrollees as of 9/30/99 • Numerator: Number of enrollees on 9/30/03: 101,724 • Denominator: Number of enrollees on 9/30/99: 51,089
		Progress Summary: The number of children enrolled in Title XIX increased by 9,023 or nearly 10% in FFY03. As of 9/30/03, Idaho had increased enrollment by 50,635 children, an increase of 99%.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
To ensure that enrolled children have a medical home.	There will be a 10% annual increase in the number of children participating in Healthy Connections and having a primary care provider as a "medical home".	New/Revised Continuing X
		Data Sources: Division of Medicaid, Healthy Connections (PCCM) Program
		• Methodology: Baseline data on the number of children in the Healthy Connections is known. The data system will track new enrollees in the program • Numerator: Number of children enrolled in HC at the end of the FFY 9/30/03: 88,415 • Denominator: Number of children enrolled in HC at the beginning of the FFY 10/1/00: 25,661
		Progress Summary: Healthy Connections enrollment increased by 37,058 children in FFY 03, a 72% increase for the year and a 244% increase over the baseline. Percent of children participating rose from 49% to 80%.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
To ensure that enrolled	90% of enrolled children will	New/Revised Continuing X

children receive appropriate and necessary medical care.	have up-to-date, age-appropriate vaccinations. 80% of enrolled children age 12 months and younger will have received appropriate preventive care.	Data Sources: Division of Medicaid information system, Division of Health Immunization Registry
		• Methodology: Claims data will be reviewed for immunization and preventive care visits. The immunization registry is being used to track immunization levels. • Numerator: Number of children with up-to-date immunizations and preventive care visits. • Denominator: Total number of Title XIX and XXI children.
		Progress Summary: No change- At this time, Idaho is examining the data collection criteria to report wellness visits. The FFY02 HCFA416 report indicates that the screening ratio for children <1 year of age has dropped to 25%. However this is believed to be currently underreported. FFY03 data is not available at the time of this report. Medicaid will be addressing the issue of correct coding for wellness visits in FFY04. Immunizations: No change. For the first three series of shots, Idaho's rate of immunizations is in the low 90s. By the time children are ready to go to school the rate is approximately 95%. Similar to other states, rates reflect a decline in the percentage for the 2 year old age group.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Performance goals are listed in Table 9.1.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.

The State of Idaho uses a modified set of National Performance measures.

- Well child visits for children in the first 15 months of life.
- Well child visits in the 3rd, 4th, 5th, and 6th years of life.
- Use of appropriate medications for children with asthma.
- Comprehensive diabetes care (hemoglobin A1c tests).
- Children's access to primary care services.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
9.3.7.1. ☐ Immunizations
9.3.7.2. ☐ Well childcare
9.3.7.3. ☐ Adolescent well visits
9.3.7.4. ☐ Satisfaction with care
9.3.7.5. ☐ Mental health
9.3.7.6. ☐ Dental care
9.3.7.7. ☐ Other, please list:
9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

The assessments will be built upon the data obtained to monitor the achievement of the strategic objectives listed in Table 9.1.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

Public hearings, advertised through prior public notice, are held in conjunction with Administrative Rules promulgation required to amend eligibility or benefits for the Children's Health Insurance Program. These hearings allow public comment on the entire program. Public notification of proposed changes to Administrative Rules is published the first Wednesday of each month in the Administrative Bulletin and also posted to the state's website.

- Chronic Disease Management (CDM)- the changes requested were never implemented in the program. No participants had ever received CDM for the medical conditions being removed from the state plan.
- Therapies (Speech Language Pathology services)- the public notice was published on October 1, 2008. Public hearings were held on October 1st, 15th & 17th, 2008.
- Substance Abuse Treatment Services- the public notice was published on October 1, 2008. A public hearing was held on October 14, 2008.
- Partial care & PSR (mental health services)- the public notice was published on October 1, 2008. Public hearings were held on October 1st, 15th & 17th, 2008. A letter to all participants enrolled in the Enhanced Plan was sent on November 26, 2008.
- Developmental Disabilities Agency Services- the public notice was published on January 7, 2009. Public hearings were held on January 12th, 13th & 14th, 2009. A letter to all participants enrolled in the Enhanced Plan was sent on November 26, 2008.
- All changes for SPA #11- public notice was published on December 1, 2010. A letter to participants was sent on December 1, 2010.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Budget

Benefit Costs	2010	2011	2012
Insurance payments	-	-	-
Managed Care	39,687,276.92	43,567,939.04	45,621,584.32
Fee for Service	4,409,697.44	4,840,882.12	5,069,061.92
Total Benefit Costs	44,096,974.35	48,408,821.16	50,690,649.24
(Offsetting beneficiary cost sharing payments)	(1,981,518.74)	(2,057,606.18)	(2,136,923.28)
Net Benefit Costs	42,115,455.61	46,351,214.98	48,553,725.96

Administration Costs			
Personnel	-	-	-
General Administration	607,720.91	638,106.95	670,012.30
Contractors/Brokers (e.g., enrollment contractors)	-	-	-
Claims Processing	18,527.85	19,454.24	20,426.95
Outreach/Marketing costs	-	-	-
Other (e.g., indirect costs)	-	-	-
Health Services Initiatives	2,147,553.02	2,254.930.67	2,367,677.21
Total Administration Costs	2,773,801.78	2,912.491.87	3,058,116.47
10% Administrative Cap (net benefit costs ÷ 9)	4,679,495.07	5,150,135.00	5,394,858.44

Federal Title XXI Share	35,273,488.47	40,469,198.64	42,392,208.74
State Share	11,521,462.21	11,032,151.33	11,556,375.66

TOTAL COSTS OF APPROVED SCHIP PLAN	46,794,950.68	51,501,349.97	53,948,584.40

	2010		2011		2012	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Separate program	12,995	153.57	12,277	176.12	11,455	192.92
Expansion program	11,996	139.98	13,347	140.24	14,277	141.09

Effective Date: January 1, 2011 Approval Date:

State match for CHIP participants with family incomes between 150% and 185% FPL is collected through a state-imposed premium tax on insurance policies sold within the State. A portion of these funds is dedicated to CHIP funding via Idaho statute. The premium tax that funds this portion of the program is imposed on all entities that sell insurance (not just health insurance) in Idaho. Less than 85 percent of the premium tax burden falls on health care providers. The premium tax collections from health insurance are treated the same as premium tax collections from other types of insurance. Therefore, this premium tax does not meet the definition of a "health-care related tax" as defined in 42 CFR §433.55.

State match for CHIP participants with family incomes between 133% and 150% FPL is appropriated from the state General Fund.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 10.3-D ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website.

Section 11. Program Integrity (Section 2101(a))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1. ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections *(Sections 2101(a))*

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

12.1. Eligibility and Enrollment Matters

Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

The State of Idaho uses a review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Idaho CHIP will use the same Fair Hearing rights and process for CHIP as for Idaho Medicaid. Families are informed of their rights and responsibilities upon application for coverage and via the "Notice of Decision" sent upon eligibility determination. A Fair Hearing can be requested to review any adverse decision made in determining eligibility or enrollment.

12.2. Health Services Matters

Please describe the review process for health services matters that comply with 42 CFR 457.1120.

The State of Idaho uses a review process for health services matters that complies with 42 CFR 457.1120. Upon enrollment, participants are provided instruction and contact information regarding how to file a grievance or make a complaint regarding service delivery. Idaho CHIP uses the same Fair Hearing rights and process for CHIP as for Idaho Medicaid.

12.3. Premium Assistance Programs

If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable.