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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 14-0014

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104



Division of Medicaid & Children's Health Operations

OCT 21 2014

Richard Armstrong, Director
Department of Health and Welfare
Towers Building – Tenth Floor
Post Office Box 83720
Boise, Idaho 83720-0036

RE: Idaho State Plan Amendment (SPA) Transmittal Number 14-0014

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 14-0014. This SPA restores dental services to adults (21 years of age and older) with disabilities and special care needs who are enrolled in the Enhanced Plan. Services are provided through the Idaho Smiles program under a mandatory managed care delivery system contracted with Blue Cross of Idaho/DentaQuest.


As a reminder, all requirements pertaining to ABPs must be met, including, but not limited to: benefits, payment rates, reimbursement methodologies, cost-sharing state plan pages, and service delivery requirements. Amendments to Idaho's approved Medicaid program (SPAs, waivers, contracts) may require corresponding amendments to the ABP if the change to the benefit in the approved State plan will be mirrored in the ABP. In addition, Idaho must be mindful of submission timeframes in order to achieve effective date consistency related to the provision of benefits to eligible individuals, and in order to claim Title XIX expenditures via the quarterly CMS-64.

The CMS would also like to take this opportunity to remind the state it must assure compliance with all Medicaid requirements, including those related to State Fair Hearings at 1902(a)(3) and 1902 (a) (4) of the Act and as written in 42 C.F.R. 431.10(c)(2).

This SPA, ID 14-0014, is approved effective July 1, 2014, as requested by the state.

If you have any additional questions or require any further assistance related to the approval of this SPA, please contact me, or have your staff contact Kendra Sippel-Theodore at (206) 615-2065 or Kendra.Sippel-Theodore@cms.hhs.gov.

Sincerely,



Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's
Health Operations

cc:

Denise Chuckovich, State Medicaid Director, Department of Health & Welfare
Lisa Hettinger, Medicaid Benefits Administrator, Division of Medicaid

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: Idaho

Transmittal Number:

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

14-0014

Proposed Effective Date

07/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Section 2302 of the Affordable Care Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	\$ 827225.00
Second Year	2015	\$ 3308900.00

Subject of Amendment

Dental benefits are restored for Enhanced Plan participants effective 7/1/2014.

Governor's Office Review

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

Describe:

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

Describe:

Signature of State Agency Official

Submitted By: Rachel Strutton
 Last Revision Date: Oct 16, 2014
 Submit Date: Aug 18, 2014

DATE RECEIVED: Aug 18, 2014	DATE APPROVED: 10/21/2014
PLAN APPROVED-ONE COPY ATTACHED	
EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2014	SIGNATURE OF REGIONAL OFFICIAL: /S/
TYPED NAME Carol J.C. Peverly	TITLE: Associate Regional Administrator Division of Medicaid and Children's Health



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Benefits Description ABP5

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

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

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

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

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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

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

“Secretary-Approved”



Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services

Collapse All

Benefit Provided:

Primary Care Visit to Treat an Injury or Illness

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Specialist Visit

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Selected services require PA.

Benefit Provided:

Other Practitioner Office Visit

Source:

Base Benchmark Small Group

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

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

Selected services require PA.

Remove

Benefit Provided:	Source:	Remove
Outpatient Facility Fee (e.g., ASC)	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Prior Authorization	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		

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

Ambulatory Surgery Center (ASC);
Selected services require prior authorization.

Benefit Provided:	Source:	Remove
Outpatient Surgery Physician/ Surgical Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Prior Authorization	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		

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

Selected services require prior authorization.

Benefit Provided:	Source:	
Urgent Care Centers or Facilities	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	None	



Alternative Benefit Plan

Scope Limit:	<input type="text" value="None"/>	<input type="button" value="Remove"/>
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text"/>		

Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Chiropractic Care"/>	<input type="text" value="Base Benchmark Small Group"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="Authorization required in excess of limitation"/>	<input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="6 Visits"/>	<input type="text" value="None"/>	
Scope Limit:	<input type="text" value="None"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="The Department will review for medical necessity and prior authorize chiropractic services after the initial six visits per year."/>		

Benefit Provided:	Source:	<input type="button" value="Remove"/>
<input type="text" value="Radiation Therapy"/>	<input type="text" value="Base Benchmark Small Group"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:	<input type="text" value="None"/>	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text"/>		

Benefit Provided:	Source:	
<input type="text" value="Renal Dialysis"/>	<input type="text" value="Base Benchmark Small Group"/>	
Authorization:	Provider Qualifications:	
<input type="text" value="None"/>	<input type="text" value="Selected Public Employee/Commercial Plan"/>	



Alternative Benefit Plan

Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	<input type="button" value="Remove"/>
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Respiratory Therapy"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Enterostomal Therapy"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Home IV Therapy"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	



Alternative Benefit Plan

Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		

Benefit Provided: <input type="text" value="Hospice"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input 1937="" base="" benchmark."="" benefits"="" excess="" for="" in="" of="" other="" provided="" services="" the="" type="text" value="Concurrent care for children under the age of 21 is covered.

Medicaid covers hospice services beyond the \$10,000 lifetime limit covered by the Base Benchmark.

See "/>		



Alternative Benefit Plan

<input checked="" type="checkbox"/> Essential Health Benefit 2: Emergency services		Collapse All <input type="checkbox"/>															
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Emergency Room Services"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/></td></tr></table>			Benefit Provided: <input style="width: 95%;" type="text" value="Emergency Room Services"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Emergency Room Services"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>															
Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>																
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>																
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>																	
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Emergency Transportation/Ambulance"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="Retroactive Authorization"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/></td></tr></table>			Benefit Provided: <input style="width: 95%;" type="text" value="Emergency Transportation/Ambulance"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="Retroactive Authorization"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Emergency Transportation/Ambulance"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>															
Authorization: <input style="width: 95%;" type="text" value="Retroactive Authorization"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/>																
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>																
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>																	
		<input type="button" value="Add"/>															



Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital Services (e.g., Hospital Stay)

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Inpatient stays are reviewed by the Department or its contractor after three days, or in four days if the participant has had a cesarean section.

Selected services require a PA.

Benefit Provided:

Inpatient Physician and Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Selected services require prior authorization.

Benefit Provided:

Radiation Therapy: Inpatient

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

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

Remove

Add



Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care Collapse All

Benefit Provided:

Prenatal and Postnatal care

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

See "Other 1937 Benefits" for additional provider types covered beyond the Base Benchmark: Other Licensed Practitioner, Licensed Midwife

Benefit Provided:

Delivery and All Inpatient Services-Maternity Care

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Freestanding Birth Centers are not a recognized provider type in Idaho and are not approved for Idaho Medicaid payment. Freestanding Birth Centers are not licensed in Idaho.

Add



Alternative Benefit Plan

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

Collapse All

Benefit Provided:

Substance Abuse Disorder Outpatient Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Qualified Providers:

- 1) Licensed physician,
- 2) Advanced Practice Professional Nurse,
- 3) Physician Assistant
- 4) Licensed Social Worker
- 5) Licensed Counselor
- 6) Licensed Marriage and Family Therapist
- 7) Providers who hold at least a Bachelor degree, a Certification or Licensing in their field, and meet requirements of Idaho Department of Health and Welfare or its Contractor
- 8) Licensed Psychologist, Psychologist Extender-(Registered with the Idaho Bureau of Occupational Licensing)
- 9) Registered Nurse

Services rendered by a physician are subject to the program integrity controls.

Benefit Provided:

MH/BH Inpatient Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Mental Health/Behavioral Health Inpatient Services.

Services are not provided in an IMD.



Alternative Benefit Plan

Benefit Provided:	Source:	Remove
Substance Abuse Disorder Inpatient Services	Secretary-Approved Other	
Authorization:	Provider Qualifications:	
Prior Authorization	Other	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
The Department covers Substance Abuse Disorder Inpatient Services with services that are the same as the Base Benchmark with the exception of Residential Treatment services.		
Services are not provided in an IMD.		

Benefit Provided:	Source:
Community-Based Rehabilitation Services	Secretary-Approved Other
Authorization:	Provider Qualifications:
Prior Authorization	Other
Amount Limit:	Duration Limit:
None	None
Scope Limit:	
None	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
Program Description: Community-based rehabilitation services (CBRS); 1905(a)(13)(C) of the Act	
- CBRS services consist of evidence-based practices that are restorative interventions or interventions that reduce disability and that are provided to participants with serious, disabling mental illness, emotional disturbance or substance use disorders for the purpose of increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology or eliminating or reducing alcohol and drug use and implementing structure and support to achieve and sustain recovery, and ensuring a satisfactory quality of life. Services include treatment planning, and the provision and coordination of treatments and services delivered by multidisciplinary teams under the supervision of a licensed behavioral health professional staff, physician or nurse.	
- Interventions for psychiatric symptomatology will use an active, assertive outreach approach and including use of a comprehensive assessment and the development of a community support treatment plan, ongoing monitoring and support, medication management, skill restoration, crisis resolution and accessing needed community resources and supports.	



Alternative Benefit Plan

- Interventions for substance use disorders, will include substance use disorder treatment planning, psycho-education and supportive counseling which are provided to achieve rehabilitation and sustain recovery and restoration of skills needed to access needed community resources and supports. These services are provided in conjunction with any professional or therapeutic behavioral health services identified as necessary for the member.
- Services may be provided by one of the following contracted professionals when provided within the scope of their practice:
 - 1) Licensed physician,
 - 2) Advanced Practice Professional Nurse,
 - 3) Physician Assistant
 - 4) Licensed Social Worker
 - 5) Licensed Counselor
 - 6) Licensed Marriage and Family Therapist
 - 7) Providers who hold at least a Bachelor degree, are Licensed or certified in their field (i.e. Adult or Children's Certificate in Psychosocial Rehabilitation), and who meet requirements of Idaho Department of Health and Welfare or its Contractor
 - 8) Licensed Psychologist, Psychologist Extender-(Registered with the Idaho Bureau of Occupational Licensing)
 - 9) Registered Nurse

Remove

Benefit Provided:

Partial Care

Source:

Secretary-Approved Other

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Program Description: Partial Care Treatment; 1905(a)(6) of the Act.

- Services are prior authorized, and there is no limitation is amount, duration nor scope.
- A distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care that is reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or reduce disability or restore the individual's condition and functional level and to prevent relapse or hospitalization. These services occur through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition.
- Partial Care is a program of services that include support therapy, medication monitoring, and skills building as appropriate for the individual. Each service must be delivered by a person licensed or certified to deliver those services.
- Partial Care Treatment may be provided by one of the following contracted licensed or certified professionals when provided within the scope of their practice:



Alternative Benefit Plan

- 1) Licensed physician,
 - 2) Advanced Practice Professional Nurse,
 - 3) Physician Assistant
 - 4) Licensed Social Worker
 - 5) Licensed Counselor
 - 6) Licensed Marriage and Family Therapist
 - 7) Providers who hold at least a Bachelor degree and are Licensed Social Workers
 - 8) Licensed Psychologist, Psychologist Extender-(Registered with the Idaho Bureau of Occupational Licensing)
 - 9) Registered Nurse
- These licensed practitioners provide supervision to unlicensed practitioners including certified alcohol and drug counselors.
 - Such supervision is included in the State's Scope of Practice Act for the supervising licensed practitioner.
 - The licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner.

Remove

Benefit Provided:

MH/BH Outpatient Services: Group therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

MH/BH Outpatient: Family and Individual Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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



Alternative Benefit Plan

Benefit Provided:		Source:	
<input type="text" value="MH/BH Outpatient: ECT Therapy"/>		<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization:	<input type="text" value="Prior Authorization"/>	Provider Qualifications:	<input type="text" value="Selected Public Employee/Commercial Plan"/>
Amount Limit:	<input type="text" value="None"/>	Duration Limit:	<input type="text" value="None"/>
Scope Limit:	<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
<input type="text"/>			
Benefit Provided:		Source:	
<input type="text" value="MH/BH Outpatient Services:Med Management"/>		<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization:	<input type="text" value="Prior Authorization"/>	Provider Qualifications:	<input type="text" value="Selected Public Employee/Commercial Plan"/>
Amount Limit:	<input type="text" value="None"/>	Duration Limit:	<input type="text" value="None"/>
Scope Limit:	<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
<input type="text"/>			
			<input type="button" value="Add"/>



Alternative Benefit Plan

Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

The Department covers at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class.

Prior Authorization criteria is developed by the Department's clinical pharmacists with input from the Medical Director, the Pharmacy and Therapeutics Committee, and the Drug Utilization Review Board. The criteria used to place drugs on prior authorization is based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug, and quality evidence provided by established drug compendia, and the Drug Effectiveness Review Program.

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



Alternative Benefit Plan

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

Benefit Provided:

Home Health Care Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

100 visits per year

Duration Limit:

None

Scope Limit:

Skilled Nursing, Home Health Aide, Occupational Therapy (OT), Physical Therapy (PT), and Speech Language Pathology (SLP) services when provided through a Home Health Agency.

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

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

Benefit Provided:

Outpatient Rehabilitation Services: PT, OT, SLP

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

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

The Base Benchmark limit is up to 20 visits for all occupational therapy (OT), speech-language pathology services (SLP) & physical therapy (PT) combined & includes both rehabilitation and habilitation.

See Outpatient Rehabilitation services in excess of the Base Benchmark in "Other 1937 Benefits".

Benefit Provided:

Habilitation Services

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

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

Remove

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

The Base Benchmark limit is up to 20 visits for all occupational therapy (OT), speech-language pathology services (SLP) & physical therapy (PT) combined & includes both rehabilitation and habilitation.

See Habilitation Services in excess of the Base Benchmark in "Other 1937 Benefits."

Benefit Provided:

Durable Medical Equipment

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Items which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease or Illness, and are appropriate for use in the beneficiary's home.

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

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

Benefit Provided:

Skilled Nursing Facility

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Skilled Nursing Facility services for rehabilitation.

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

See "Other 1937 Benefits" for services in excess of the Base Benchmark limit of \$5,000 per year.

Add



Alternative Benefit Plan

<input checked="" type="checkbox"/> Essential Health Benefit 8: Laboratory services	Collapse All <input type="checkbox"/>															
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Diagnostic Test (X-ray & Lab Work)"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/></td></tr></table>		Benefit Provided: <input style="width: 95%;" type="text" value="Diagnostic Test (X-ray & Lab Work)"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>		
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Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>															
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																
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<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Imaging (CT/PET Scans, MRIs)Includes Nuclear Care"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/></td></tr></table>		Benefit Provided: <input style="width: 95%;" type="text" value="Imaging (CT/PET Scans, MRIs)Includes Nuclear Care"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>		
Benefit Provided: <input style="width: 95%;" type="text" value="Imaging (CT/PET Scans, MRIs)Includes Nuclear Care"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>														
Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/>															
Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>															
Scope Limit: <input style="width: 95%;" type="text" value="None"/>																
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>																
<input type="button" value="Add"/>																



Alternative Benefit Plan

Essential Health Benefit 9: Preventive and wellness services and chronic disease management

Collapse All

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

Benefit Provided:

Preventive Services

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Benefit Provided:

Preventive Care/Screening/Immunization

Source:

Secretary-Approved Other

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

The Enhanced Alternative Benefit Plan includes the following:

- Health Risk Assessment which consists of:
 - An initial health questionnaire, and
 - A well child screen, or
 - An adult physical.
- 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 administered at initial program entry and periodic intervals thereafter.



Alternative Benefit Plan

- A well child screen or adult physical conducted at periodic or interperiodic intervals which constitutes a health risk assessment will consist of a comprehensive physical examination and health education.

Remove

The Well Child Screen includes periodic medical screens and services completed at intervals recommended by the Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

The Enhanced Alternative Benefit Plan for both children and adults includes an annual preventive health visit and services with "A" and "B" recommendations by the US Prevention Services Task Force.

Benefit Provided:

Diabetes Education

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

24 hrs group sessions & 12 hrs individual per 5 yr

Duration Limit:

None

Scope Limit:

None

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

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. More can be authorized when medically necessary.

Benefit Provided:

Tobacco Cessation Counseling

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Covered in accordance with USPSTF recommendations.

Add



Alternative Benefit Plan

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

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Routine Eye Exam for children under the age of twenty-one (21).
Selected services require prior authorization.

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Orthodontia: Child
See Other 1937 Benefits for services in excess of the Base Benchmark lifetime limit of up to \$1500 or about half the usual cost.

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None



Alternative Benefit Plan

Scope Limit:

None

Remove

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

Eyeglasses for children.

Participants under the age of 21 who have been diagnosed with a visual defect and who need eyeglasses for correction of a refractive error, can receive one (1) pair of single vision or bifocal eyeglasses annually. Frames or lenses may be provided more frequently when medically necessary.

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Dental check-up for Children

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Basic Dental Care - Child

Selected services require prior authorization.

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

Base Benchmark Small Group



Alternative Benefit Plan

Authorization:	Provider Qualifications:	
<input type="text" value="Prior Authorization"/>	<input type="text" value="Selected Public Employee/Commercial Plan"/>	<input type="button" value="Remove"/>
Amount Limit:	Duration Limit:	
<input type="text" value="None"/>	<input type="text" value="None"/>	
Scope Limit:		
<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
<input type="text" value="Major Dental Care - Child"/>		
<input type="text" value="Selected services require prior authorization."/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

Other Covered Benefits from Base Benchmark

Collapse All



Alternative Benefit Plan

<input checked="" type="checkbox"/> Base Benchmark Benefits Not Covered due to Substitution or Duplication		Collapse All <input type="checkbox"/>
Base Benchmark Benefit that was Substituted: <input style="width: 90%;" type="text" value="Residential Treatment"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input style="width: 95%;" type="text" value="The Department substitutes Community-Based Rehabilitation Services and Partial Care Treatment for Residential Treatment (part of the EHB Mental/Behavioral Health Outpatient services and also Substance Abuse Inpatient services): there are no Psychiatric Residential Treatment Facilities licensed or certified in the State of Idaho."/> <input style="width: 95%;" type="text" value="This is an IMD."/>		
Base Benchmark Benefit that was Substituted: <input style="width: 90%;" type="text" value="Partial Hospitalization"/>	Source: Base Benchmark	<input type="button" value="Remove"/>
Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:		
<input style="width: 95%;" type="text" value="The Department substitutes Community-Based Rehabilitation Services and Partial Care Treatment for Partial Hospitalization (part of the EHB Mental/Behavioral Health Outpatient services)."/> <input style="width: 95%;" type="text" value="This is an IMD."/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

<input checked="" type="checkbox"/> Other Base Benchmark Benefits Not Covered	Collapse All <input type="checkbox"/>
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source: Base Benchmark
<input type="text" value="Non-Emergency Care When Traveling Outside the U.S."/>	<input type="button" value="Remove"/>
Explain why the state/territory chose not to include this benefit:	
<input type="text" value="Non-covered in accordance with federal statute."/>	
	<input type="button" value="Add"/>



Alternative Benefit Plan

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

Other 1937 Benefit Provided:

Nursing Facility: Custodial Care

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

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

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

The nursing facility benefits defined in the other 1937 section described as Nursing Facility: Rehabilitative and Nursing Facility: Custodial care along with the Skilled Nursing Facility benefit in the EHB7 section of this template reflect the state's approved nursing facility benefit in the state plan.

This service is not covered by the Base Benchmark. The Department requires that the nursing facility services include at least the items and services specified in 42 CFR 483 including 42 CFR 483.10 (c)(8)(i).

Other 1937 Benefit Provided:

Hospice

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

NONE

Scope Limit:

None

Other:

Program Description: Hospice Care; 1905(a)(18) of the Act.

Services in excess of the Base Benchmark: The Department will cover hospice services beyond the Base Benchmark limit of \$10,000 per life time.



Alternative Benefit Plan

<input type="text"/>		<input type="button" value="Remove"/>
Other 1937 Benefit Provided: <input type="text" value="Private-Duty Nursing"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Other"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Nursing services provided by a licensed registered nurse or licensed practical nurse to a non-institutionalized child under the age of 21 requiring care for conditions of such medical severity or complexity that skilled nursing is necessary."/>		
Other: <input type="text" value="Program Description: Private Duty Nursing (PDN); 1905(a)(8) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Private Duty Nursing (PDN).

Medical severity and complexity means that the child requires more individual and continuous care than is available from a visiting nurse and the needed services cannot safely be delegated to an Unlicensed Assistive Personnel.

The nursing needs must be of such a nature that the Idaho Nursing Practice Act, Rules, Regulations, or Policy require the service to be provided by an Idaho Licensed Registered 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. All PDN services are provided under the direction of a physician.

Limitations. The following service limitations apply to the Enhanced Alternative Benefit Plan covered under the State plan.
• PDN services must be authorized by the Department or its authorized agent prior 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. 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 Intellectually Disabled (ICF/ID);
• Licensed Residential Care Facilities;
• Licensed hospitals; and
• Public or private school."/>		
Other 1937 Benefit Provided: <input type="text" value="Licensed Midwife"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	



Alternative Benefit Plan

Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Services include antepartem, intrapartum, up to six (6) weeks of postpartum maternity care, and up to six weeks of newborn care."/>		
Other: <input type="text" value="Program Description: Medical Care furnished by licensed practitioners; 1905(a)(6) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Licensed Midwife (LM)

LM services include maternal and newborn care provided by LM providers within the scope of their practice and who are licensed by the Idaho Board of Midwifery."/>		
Other 1937 Benefit Provided: <input type="text" value="Orthodontia: Child"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other: <input type="text" value="Program Description:
Dental services; 1905(a)(10) of the Act and 1905(r)(3)

Services in excess of the Base Benchmark: Orthodontia.

The Department will cover complete, medically necessary orthodontia in excess of the Base Benchmark lifetime dollar limit of \$1500."/>		
Other 1937 Benefit Provided: <input type="text" value="Optometrist and Ophthalmologist Services: Adults"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	
Authorization: <input type="text" value="Authorization required in excess of limitation"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="One pair glasses or contacts post cataract surgery"/>	Duration Limit: <input type="text" value="None"/>	



Alternative Benefit Plan

Scope Limit:

None

Remove

Other:

Program Description:

- Physician Services; 1905(a)(5)(A) of the Act, and
- Medical care, or 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; 1905(a)(6) of the Act

Other services covered by the Department, but not covered by the Base Benchmark: Optometrist and Ophthalmologist Services for adults.

The Department will cover services to monitor conditions that may cause damage to the eye and acute conditions that without treatment may cause permanent damage to the eye. Up to one pair of glasses or contacts is covered post-cataract surgery.

Other 1937 Benefit Provided:

Dental Services: Adults

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Other services covered by the Department, but not covered by the Base Benchmark: Adult Dental Services

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

- ~ Preventive dental services:
 - Oral exam every 12 months
 - Cleaning every six months
 - Fluoride treatment every 12 months
 - Dental X-rays every 12 months (Full mouth or Panoramic every 36 months)
- ~ Restorative Dental Services:
 - Medically necessary exams
 - Fillings are covered once in a 24-month period per tooth/surface
 - Simple and surgical extractions
 - Endodontic services include therapeutic pulpotomy and pulpa debridement.
 - Periodontic services include scaling and root planning full mouth debridement
 - Periodontal maintenance is covered up to 2 visits every 12 months.
- ~ Dentures:
 - Dentures are covered once every 5 years.



Alternative Benefit Plan

Limitations may be exceeded if medically necessary.

Exclusions - The following non-medically necessary cosmetic services are excluded from payment under the Enhanced Benchmark Benefit Package covered under the State Plan:

- ~ Drugs supplied to dental patients for self-administration other than those allowed by applicable Department rules.
- ~ Non-medically necessary cosmetic services are excluded from payment.

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

Remove

Other 1937 Benefit Provided:

Personal Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

16 Hours per week

Duration Limit:

None

Scope Limit:

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

Other:

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

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

PCS include medically-oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence. The provider must deliver at least one (1) of the following services for a participant needing that service (as identified by the Department Nurse Reviewer):

- a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care;
- b. Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines;
- c. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need;
- d. The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the participant with developmental disabilities;
- e. Assisting the participant with physician-ordered medications that are ordinarily self-administered, when the provider has completed an Idaho State Board of Nursing approved training program and in accordance with Idaho state statute and regulations governing assistance with medications.;
- f. Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met:
 - i. The task is not complex and can be safely performed in the given participant care situation;
 - ii. A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs;
 - iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide



Alternative Benefit Plan

proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly;

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN.

PCS may also include non-medical tasks. In addition to performing at least one (1) of the services listed above, the provider may also perform the following services, if no natural supports are available:

- a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded.
- b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment.
- c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant.

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

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

PCS are furnished in an educational setting or in the participants place of residence which may include:

- Personal Residence.
- Certified Family Home. A home certified by the Department to provide care to one (1) or two (2) adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence.
- Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner.
- PCS Family Alternate Care Home. The private home of an individual licensed by the Department to provide personal care services to one (1) or two (2) children, who are unable to reside in their own home and require assistance with medically-oriented tasks related to the child's physical or functional needs.

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

Provider Qualifications: Personal care services are provided by Licensed Professional Nurse (RN), Licensed Practical Nurse (LPN), Certified Nursing Assistant (CNA) (person listed on the CNA Registry who performs selected nursing services under the supervision of a registered professional nurse person who has successfully completed a training program and holds a Certificate of Training meeting Federal eligibility requirements for listing on the Registry), or personal assistant (must be at least age eighteen (18) years of age and receive training to ensure the quality of services). Services may be provided by any qualified individual who is qualified to provide such services and who is not a member of the individual's family (legally responsible relative).

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

Personal care service providers will receive training in the following areas:



Alternative Benefit Plan

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

Remove

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

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

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Other 1937 Benefit Provided:

Target CM:Adults with Developmental Disabilities

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Other services covered by the Department, but not covered by the Base Benchmark: Target Case Management (CM) for Adults with Developmental Disabilities

Target Group (42 CFR 441.18(a)(8)(i) and 441.18(a)(9):

Adults age 18 and older, who have a developmental disability diagnosis, and who require and choose assistance to access services and supports necessary to maintain independence in the community.

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

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

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

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



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Definition of services: [42 CFR 440.169]

Target Case management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services.

Target Case Management includes the following assistance:

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

- Development (and periodic revision) of a specific care plan that:
 - Is based on the information collected through the assessment;
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities:
 - To help an eligible individual obtain needed services including activities that help link an individual with:
 - √ Medical, social, educational providers; or
 - √ Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
 - √ Services are being furnished in accordance with the individual's care plan;
 - √ Services in the care plan are adequate; and
 - √ If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.

Target Case management may include:

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

Qualifications of providers:

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



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Agency Supervisor: Education and Experience.

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

Case Manager: Education and Experience.

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

Paraprofessional: Education and Experience.

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

Freedom of choice: The State assures that the provision of target case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act. Any willing, qualified private agency may be enrolled as a service coordination agency.

- Eligible recipients will have free choice of the providers of target case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Access to Services: The State assures that:

- Target Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of target case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of target case management services; [section 1902 (a)(19)]
- Providers of target case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or target case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

The State assures that providers maintain case records that document for all individuals receiving target case management as follows [42 CFR 441.18(a)(7)]:

- The name of the individual.
- The dates of the target case management services.
- The name of the provider agency and the person providing the target case management service.
- The nature, content, units of the target case management services received and whether goals specified in the care plan have been achieved.
- Whether the individual has declined services in the care plan.



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- The need for, and occurrences of, coordination with other case managers.
- A timeline for obtaining needed services.
- A timeline for reevaluation of the plan.

Remove

Limitations:

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

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

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

Additional limitations:

- Reimbursement for on-going case management is not reimbursable prior to the completion of the assessment and service plan.
- In order to assure that no conflict of interest exists; providers of target case management may not provide both case management and direct services to the same Medicaid participant.
- Reimbursement is not allowed for missed appointments, attempted contacts, leaving messages, travel to provide the service, documenting services or transporting the participant.

Other 1937 Benefit Provided:

Outpatient Rehabilitation: OT, PT, & SLP Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Retroactive Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services are for the purpose of restoring certain functional losses due to disease, illness or injury.

Other:

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

Services in excess of the Base Benchmark: Rehabilitation Services;

The Department covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services



Alternative Benefit Plan

in excess of the Base Benchmark aggregate 20 visit limit. Claims exceeding \$1870 for OT or \$1870 for a combination of SLP and PT are subject to prepayment review for medical necessity.

Remove

Other 1937 Benefit Provided:

Outpatient Habilitation: OT, PT, and SLP Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Retroactive Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Other:

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

Services in excess of the Base Benchmark: Habilitation Services

The Department covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark aggregate 20 visit limit. Claims exceeding \$1870 for OT or \$1870 for a combination of SLP and PT are subject to prepayment review.

Other 1937 Benefit Provided:

TCM Service: Children w/ SHCN

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Limited to the target population

Other:

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

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

Target Case Management (CM) for SHCN (Services for Children with Special Health Care Needs).

~ Target Group:

Target Case Management for Children with Special Health Needs is target to cover:

- Children under the age of 21 who have special health care needs requiring medical and multidisciplinary rehabilitation services; and
- Who require and choose assistance to access services and supports necessary to maintain independence in the community.



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

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

~ Areas of State in which services will be provided:

Services will be provided throughout the entire State.

~ Comparability of services:

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

~ Definition of services: [42 CFR 440.169]

Target case management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services. Target case Management includes the following assistance:

- Initial comprehensive assessment and periodic reassessment based on the needs of the individual to determine the need for any medical, educational, social or other services. These assessment activities, conducted at least annually, or more often if necessary, are based on the individual's needs, and include:
 - o Taking client history;
 - o Identifying the individual's needs and completing related documentation;
 - o Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- Development (and periodic revision) of a specific care plan that:
 - o Is based on the information collected through the assessment;
 - o Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - o Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - o Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities:
 - o To help an eligible individual obtain needed services including activities that help link an individual with:
 - Medical, social, educational providers; or
 - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
- Monitoring and follow-up activities:
 - o Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.



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Target Case management may include:

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

~ Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Target case management must only be provided by a service coordination agency enrolled as a Medicaid provider. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator.

- Agencies must provide supervision to all case managers and all paraprofessionals.
- Any willing, qualified public or private service coordination agency may be enrolled.

Agency Supervisor - Education and Experience.

- Master's Degree in a human service field from a nationally accredited university or college and twelve (12) months experience with the target population they will be serving; or
- Bachelor's degree in human services field from a nationally accredited university or college or licensed professional nurse (RN) and twenty-four (24) months experience with the target population they will be serving.

Case Manager - Education and Experience.

- Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and twelve (12) months experience working with the target population they will be serving; or be a licensed professional nurse (RN) and twelve (12) months experience working with the target population they will be serving. Individuals who meet the education or licensing requirements but do not have the required work experience, may work as a case manager under the supervision of a qualified case manager while they gain this experience.

Paraprofessional - Education and Experience.

- Be at least eighteen (18) years of age, have a minimum of a high school diploma (or equivalency), be able to read and write at a level with the paperwork and forms involved in the provision of the service, and have twelve (12) months experience with the target population they will be serving. Under the supervision of a qualified case manager (service coordinator), a paraprofessional may be used to assist in the implementation of the service plan.

~ Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of target case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of target case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

~ Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures that:

- Target case management services will be provided in a manner consistent with best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of target case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of target case management services; [section 1902 (a)(19)]
- Providers of target case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

~ Payment (42 CFR 441.18(a)(4)):



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Payment for target case management or target case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Remove

~ Case Records (42 CFR 441.18(a)(7):

The State assures that providers maintain case records that document for all individuals receiving target case management as follows [42 CFR 441.18(a)(7)]:

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

~ Limitations:

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

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

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

Additional limitations:

- Reimbursement for on-going case management is not reimbursable prior to the completion of the assessment and service plan.
- Reimbursement is not allowed for missed appointments, attempted contacts, leaving messages, travel to provide the service, documenting services or transporting the participant.

Other 1937 Benefit Provided:

ICF/IID

Authorization:

Prior Authorization

Amount Limit:

None

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Provider Qualifications:

Other

Duration Limit:

None



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Scope Limit:

None

Remove

Other:

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

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

Other services covered by the Department, but not covered by the Base Benchmark: ICF/IID - Intermediate Care Facility for the Individual with an Intellectual Disability

Other 1937 Benefit Provided:

Bariatric Surgery

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

nONE

Scope Limit:

None

Other:

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

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

Other 1937 Benefit Provided:

Prescription Drugs

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Prescription Drugs: In excess of Base Benchmark

Non-legend products will be covered when prescribed as follows:

- Permethrin,
- Federal legend medications that change to non-legend status, as well as their therapeutic equivalents,



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based on Director approval which is determined by appropriate criteria including safety, effectiveness, clinical outcomes, and the recommendation of the P&T Committee

- Other non-legend drug products approved for coverage by the Director of the Department of Health and Welfare based on the determination of the Pharmacy and Therapeutics Committee that the non-legend product is therapeutically interchangeable with legend drugs in the same pharmacological class based on evidence comparison of efficacy, effectiveness, and safety and determined by the Department to be a cost-effective alternative.

Remove

The Department will cover either generic or brand if medically necessary.

The Department provides coverage for the following Medicare-excluded or otherwise restricted drugs or classes of drugs or their medical uses to all recipients of Medical Assistance under this State plan, including full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

- Prescription Drugs Including:
 - Lipase inhibitors subject to Prior Authorization
 - Prescription Cough & Cold symptomatic relief
 - Legend Therapeutic Vitamins which include:
 - ~ Injectable Vitamin B 12
 - ~ Vitamin K and analogues, and
 - ~ Legend folic acid
 - Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients;
 - Legend Vitamin D and analogues and
- Non-legend Products which include:
 - Permethrin
 - Other non-legend drug products approved for coverage by the Director of the Department of Health and Welfare based on the determination of the Pharmacy and Therapeutics Committee that the non-legend product is therapeutically interchangeable with legend drugs in the same pharmacological class based on evidence comparison of efficacy, effectiveness, and safety and determined by the Department to be a cost-effective alternative. Information regarding the P&T Committee and covered drug products are posted at <http://healthandwelfare.idaho.gov/Medical/PrescriptionDrugs/tabid/119/Default.aspx>

Excluded Drug products include:

- Legend drugs for which Federal Financial Participation is not available
- Ovulation stimulants and fertility enhancing drugs
- Prescription vitamins except injectable B 12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid.

Other 1937 Benefit Provided:

Prevention and Health Assistance

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Individualized benefits for individuals who are obese to address target health behaviors.



Alternative Benefit Plan

Other:

Program Description: This benefit is one of many preventive benefits that are included in this ABP. This benefit is covered in addition to the prevention and wellness benefits found in EHB9 and is being approved as Secretary-Approved Coverage.

Remove

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

The Enhanced Alternative Benefit Plan includes certain enhanced Prevention and Health Assistance (PHA) benefits for target individuals provided in accordance with applicable Department rules.

Enhanced PHA Benefits are individualized benefits to address target health behaviors. Authorizations will be managed by the State Medicaid agency. PHA benefits made available under the Enhanced Alternative Benefit Plan will be target to individuals who are obese.

PHA benefits will be available when individuals complete specified activities in preparation for addressing the target 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 weight reduction/management rules. These goods and services may include weight-loss programs, dietary supplements, and other health related benefits.

Other 1937 Benefit Provided:

Home Health Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

100 visits per year

Duration Limit:

None

Scope Limit:

None

Other:

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

Services covered in excess of the Base Benchmark: The Base Benchmark covers up to \$5,000 per year or about 50 visits for Home Health Services.

The Department will cover up to 100 visits without PA for any combination of Skilled Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, or Speech-Language Pathology services. More can be authorized when medically necessary.

Other 1937 Benefit Provided:

Nursing Facility: Rehabilitative

Source:

Section 1937 Coverage Option Benchmark Benefit Package



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Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other: <input type="text" value="Program Description: Nursing facility services; 1905(a)(4)(A) of the Act.
Services in excess of the Base Benchmark: Skilled Nursing Facility

The Base Benchmark covers nursing facilities for rehabilitation and limits care to 30 days per year for only certain conditions. The Department will cover rehabilitative skilled nursing facility services in excess of the 30 days per year covered by the Base Benchmark if the participant is showing progress toward rehabilitation goals.

The nursing facility benefits defined in the other 1937 section described as Nursing Facility: Rehabilitative and Nursing Facility: Custodial care along with the Skilled Nursing Facility benefit in the EHB7 section of this template reflect the state's approved nursing facility benefit in the state plan.

The Department requires that the nursing facility services include at least the items and services specified in 42 CFR 483 including 42 CFR 483.10 (c)(8)(i)."/>		
Other 1937 Benefit Provided: <input type="text" value="Durable Medical Equipment"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other: <input type="text" value="Program Description: Home health care services; 1905(a)(7) of the Act.
Services in excess of the Base Benchmark: DME
- The Department covers some items not covered by the Base Benchmark.
- The Department will replace DME more frequently than five (5) years when determined to be medically necessary."/>		
Other 1937 Benefit Provided: <input type="text" value="Podiatrist Services"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	



Alternative Benefit Plan

Authorization: Prior Authorization	Provider Qualifications: Other	Remove
Amount Limit: None	Duration Limit: None	
Scope Limit: Services to diagnose and treat medical conditions affecting the foot, ankle and related structures.		
Other: Program Description: Medical Care furnished by licensed practitioners; 1905(a)(6) of the Act. Other services covered by the Department, but not covered by the Base Benchmark: Podiatrist Services Routine foot care is not covered.		
Other 1937 Benefit Provided: Individual and Family Medical Social Services	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization: Prior Authorization	Provider Qualifications: Other	
Amount Limit: Two visits	Duration Limit: Pregnancy and six weeks post-partum	
Scope Limit: None		
Other: Program Description: Medical Care; 1905(a)(6) – Medical care, or 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; Other services covered by the Department, but not covered by the Base Benchmark: 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. Additional services may be prior authorized.		
Other 1937 Benefit Provided: Diabetes Education	Source: Section 1937 Coverage Option Benchmark Benefit Package	
Authorization: Authorization required in excess of limitation	Provider Qualifications: Selected Public Employee/Commercial Plan	
Amount Limit: None	Duration Limit: None	



Alternative Benefit Plan

Scope Limit:

None

Remove

Other:

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

Services in excess of the Base Benchmark: Diabetes Education

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. Additional services may be prior authorized when medically necessary.

Other 1937 Benefit Provided:

Target Case Management Services: Idaho Behavioral

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

- Other services covered by the Department, but not covered by the Base Benchmark: Target Case Management in the Idaho Behavioral Health Program.
- Services are prior authorized, and there is no limitation in amount, duration nor scope.
- The target group consists of members of the Idaho Behavioral Health Plan who are:
 1. Adults 18 and older with serious and persistent mental illness or other behavioral health diagnosis; or;
 2. Children up to age 21 with serious emotional disturbance or other behavioral health diagnosis, and;
 3. Who demonstrate medical necessity for case management services and require and choose assistance to access services and supports necessary to maintain independence in the community.

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

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

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

~ Comparability of services: Services are not comparable in amount, duration and scope (§1915(g)(1)).

~ Definition of services: [42 CFR 440.169]



Alternative Benefit Plan

Behavioral Health Target Case Management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services. Target case Management includes the following assistance:

- Initial assessment and annual reassessment of an individual to determine the need for any medical, educational, social or other services. More frequent reassessments may be done more frequently if medically necessary. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation;
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities to help an eligible individual obtain needed services including activities that help link an individual with:
 - Medical, social, educational providers; or Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
- Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
 - ~ Services are being furnished in accordance with the individual's care plan;
 - ~ Services in the care plan are adequate; and
 - ~ If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.

~ Target case management may include:

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

~ Qualifications of Providers:

The Target Case Management benefit is provided by a PAHP contracted and qualified provider as established by the contract, and set forth below for minimum provider qualifications. Service providers are subject to the limitations of practice imposed by State Law, Federal Regulations, The State of Idaho Occupational Licensing requirements, the provider's professional area of competency and as according to applicable Department Rules, approval by the Department and its Pre-paid Ambulatory Health Plan (PAHP) Contractor as established in the Contract.

- Minimum Provider Qualifications for Target Case Management Providers are PAHP contractors: Licensed Physician, Licensed Psychiatrist, Licensed Practitioner of the Healing Arts (Advanced Practice Nurse, Nurse Practitioner, Physician Assistant), Licensed Prof. Nurse, RN, Cert. Psychiatric Nurse, RN, Licensed Prof. Nurse, RN, Licensed Social Worker, Licensed Counselor, Licensed Psychologist, Psychologist Extender-(Registered with the Idaho Bureau of Occupational Licenses) Licensed Marriage and Family Therapist, Hold at least a Bachelor's degree and a Certification or Licensing in their field and meet requirements of Idaho Department of Health and Welfare or its Contractor, Licensed Registered Occupational Therapist.



Alternative Benefit Plan

~ Waiver of Freedom of Choice of Providers

As permitted and authorized under section 1915 (b)(4) of the Social Security Act, choice of target case management providers is waived. Behavioral Health target case management will be provided by the prepaid ambulatory health plan for the Idaho Behavioral Health Plan.

- Eligible recipients will have free choice of providers of other medical care under the state plan.

~ Freedom of Choice Exception (1915(g)(1) and 42 CFR 441.18(b):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

~ Access to Services:

The State assures that:

Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]

Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]

Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

~Payment (42 CFR 441.18(a)(4)):

Payment for case management or target case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

~Case Records (42 CFR 441.18(a)(7)):

The State assures that providers maintain case records that document for all individuals receiving case management as follows [42 CFR 441.18(a)(7)]:

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

~Limitations:

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

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



Alternative Benefit Plan

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

Remove

Other 1937 Benefit Provided:

Institution for Mental Diseases for Adults over 65

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Inpatient Services for individuals with mental disease.

Other:

Program Description: In addition to Psychiatric Services covered under Inpatient Hospital Services, the Enhanced Alternative Benefit Plan includes Services for Certain Individuals in Institutions for Mental Diseases permitted under sections 1905(a)(14) of the Social Security Act.

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

Inpatient hospital services for individuals Age 65 or Over in Institutions for Mental Diseases include services provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620 (c) and (d) are met.

The Department provides assurance that providers of inpatient psychiatric services for individuals under 21 shall meet the requirements of 42 CFR 440.160(b) and Subpart D of 42 CFR 441 regarding certification and accreditation requirements.

The Department provides assurance that inpatient psychiatric services for individuals under 21 comply with restraint and seclusion requirements at 42 CFR 483 Subpart G.

Other 1937 Benefit Provided:

Dentures

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

One set per five years

Duration Limit:

None



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Scope Limit:

None

Remove

Other:

Dentures for the purpose of restoring oral form and function due to loss of permanent teeth that would result in significant occlusal dysfunction are only covered for children through the month of their twenty-first (21st) birthday, and pregnant women when medically necessary.

Other 1937 Benefit Provided:

Audiology

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Certain services require PA.

Audiologist services are covered for individuals with hearing disorders when provided by an audiologist who is licensed by the Speech and Hearing Services Board in the Idaho Board of Occupational Licensing.

- ~ Participants age 21 and older are eligible to receive diagnostic audiology services necessary to obtain a differential diagnosis.
- ~ Participants under the age of 21 are eligible to receive necessary audiometric services and supplies.
- ~ The Department will prior authorize audiometric examination/testing if needed more frequently than once per year.

Other 1937 Benefit Provided:

Behavioral Consultation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

- Behavioral consultation supports a multi-disciplinary approach to rehabilitative and treatment by consulting with the IEP team during the assessment process for a specific child, performing advanced



Alternative Benefit Plan

assessment of the child, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members for a child's needs.

Remove

Behavioral consultation provides expertise for children with complex needs who are not demonstrating outcomes with behavioral interventions alone. The consultant works with the IEP team and other professionals to develop a positive behavior support plan and provide oversight in carrying out that plan to reduce disability and increase function.

- Qualifications for Behavioral Consultation are:

- ~ Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and who meets one (1) of the following:
- ~ An individual with an Exceptional Child Certificate as defined by State law.
- ~ An individual with an Early Childhood/Early Childhood Special Education Blended Certificate as defined by State law.
- ~ A Special Education Consulting Teacher as defined by State law.
- ~ An individual with a Pupil Personnel Certificate as defined by State law, excluding a registered nurse or Audiologist.
- ~ An occupation therapist who is qualified and registered to practice in Idaho.
- ~ Therapeutic consultation professional who meets the requirements defined by the Department.

- Services provided in the schools must be the same in amount, duration and scope as the services provided in the community.
- Individuals delivering services in the schools must adhere to the same provider qualifications as required for individuals delivering services in the community.
- Beneficiaries are able to choose to receive Medicaid services from the pool of qualified Medicaid providers, which include school-based and community providers.
- Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department

Other 1937 Benefit Provided:

Behavioral Intervention

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

- Program Description: Behavioral Intervention: 1905(a)(13)(C) of the Act.

- Other services covered by the Department, but not covered by the Base Benchmark: Behavioral Intervention



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- Behavioral intervention is based on a treatment plan developed by the family and a multidisciplinary team who also writes the IEP.
- Behavioral Intervention is used to promote the student’s ability to participate in educational services through a consistent, assertive, and continuous intervention process. It includes the development of replacement behaviors with the purpose to prevent or treat behavioral conditions of students who exhibit maladaptive behaviors.
- The behavioral intervention treatment plan is developed and implemented by the multi-disciplinary team. The parents/guardian are included in the development of the plan.
- Qualifications for a Behavioral Intervention Professional are as follows:
 - ~ An individual with an Exceptional Child Certificate as defined by State law; or
 - ~ An individual with an Early Childhood/Early Childhood Special Education Blended Certificate as defined by State law; or
 - ~ A Special Education Consulting Teacher as defined by State law; or
 - ~ Habilitative intervention professional who meets the requirements defined by the Department; or
 - ~ Individuals employed by a school as certified Intensive Behavioral Intervention (IBI) professionals prior to July 1, 2013, are qualified to provide behavioral intervention; and
 - ~ Must be able to provide documentation of one (1) year’s supervised experience working with children with developmental disabilities.
- Qualifications for a Behavioral Intervention Paraprofessional are as follows:
 - ~ Must be at least eighteen (18) years of age;
 - ~ Demonstrate the knowledge, have the skills needed to support the program to which they are assigned, and meet the requirements under the “Standards for Paraprofessionals Supporting Students with Special Needs,” available online at the State Department of Education website; and
 - ~ Must meet the paraprofessional requirements under the Elementary and Secondary Education Act of 1965, as amended, Title 1, Part A, Section 1119.
 - ~ A paraprofessional delivering behavioral intervention services must be under the supervision of a behavioral intervention professional or behavioral consultation provider.

Remove

Add



Alternative Benefit Plan

<input type="checkbox"/> Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)	Collapse All <input type="checkbox"/>
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PRA Disclosure Statement

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

V.20130808



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Service Delivery Systems

ABP8

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

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

Select one or more service delivery systems:

- Managed care.
 - Managed Care Organizations (MCO).
 - Prepaid Inpatient Health Plans (PIHP).
 - Prepaid Ambulatory Health Plans (PAHP).
 - Primary Care Case Management (PCCM).

- Fee-for-service.
- Other service delivery system.

Managed Care Options

Managed Care Assurance

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

Managed Care Implementation

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

The Contractor is pursuing outreach activities with the goal of improving access to preventive services for children and adults and to address the problems of early childhood dental caries by ensuring that children ages 0 - 3 have a dental home. The contract requires that the Contractor conduct outreach activities and programs to educate participants about their dental benefits and the importance of preventive dental care. Outreach efforts are to focus on the best and most cost-effective use of resources. Outreach may be accomplished through a variety of methods including, but not limited to, mailings, newsletters, website information, and contractor affiliations with other community, healthcare, and government health outreach programs.

PAHP: Prepaid Ambulatory Health Plan

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

No

- The Alternative Benefit Plan will be provided through a prepaid ambulatory health plan (PAHP) consistent with applicable managed care requirements (42 CFR Part 438, and section 1937 of the Social Security Act).
- PAHPs are paid on a risk basis.
- PAHPs are paid on a non-risk basis.

PAHP Procurement or Selection Method

Indicate the method used to select PAHPs:



Alternative Benefit Plan

Competitive procurement method (RFP, RFA).

Other procurement/selection method.

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

Other PAHP-Based Service Delivery System Characteristics

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

	Benefit/service	Description of how the benefit/service will be provided	
+	The only dental service provided outside the PAHP is for fluoride varnish.	Pediatricians who have been trained may bill for providing fluoride varnish.	X
+	Interpretation services	Dentists bill Medicaid directly for Interpretation services	X

PAHP service delivery is provided on less than a statewide basis.

PAHP Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan:

General PAHP Participation Requirements

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

Mandatory participation.

Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in PAHPs:

All participants enrolled in the Enhanced Alternative Benefit Plan are eligible to receive full dental benefits from the PAHP. The single state agency enrolls and disenrolls participants for Medicaid coverage. An eligibility data file is sent to the Contractor daily. The contract requires the dental benefit administrator to enroll or disenroll based solely on the eligibility information supplied by the single state agency. If a participant loses Medicaid eligibility, they are disenrolled from the dental plan, but are automatically reenrolled with the Contractor when they again become Medicaid eligible with no waiting period for enrollment.

Additional Information: PAHP (Optional)

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

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Alternative Benefit Plan

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