Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 17-0006

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

May 16, 2017

Richard Armstrong, Director
Department of Health and Welfare
Towers Building - Tenth Floor
P.O. Box 83720
Boise, ID 83720-0036

RE: Idaho State Plan Amendment (SPA) Transmittal Number 17-0006

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the enclosed State Plan Amendment (SPA), Transmittal Number 17-0006. This SPA amends Idaho's Enhanced Alternative Benefit Plan (ABP) by adding endorsed/certified school psychologist as individuals who can provide supervision for Community-Based Rehabilitation Services (CBRS) providers.

This SPA is approved effective January 1, 2017. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Idaho State Plan.

If there are any questions concerning this approval, please contact me or your staff may contact Walter Neal at walter.neal@cms.hhs.gov or at 206-615-2330.

Sincerely,

Digitally signed by David L. Meacham -

[redacted]

Date: 2017.05.19 10:47:41 -07'00'

David L. Meacham
Associate Regional Administrator

Enclosure

cc:
Matt Wimmer, Administrator

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Idaho**

Transmittal Number:

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

ID-17-0006

Proposed Effective Date

01/01/2017 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1905(a)(13)(C)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year		$ 0.00
Second Year		$ 0.00

Subject of Amendment

CBRS supervision of services.

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:	**Dea Kellom**
Last Revision Date:	**May 9, 2017**
Submit Date:	**Mar 21, 2017**

Alternative Benefit Plan

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

Attachment 3.1-C- N

Alternative Benefit Plan Populations — ABP1

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

Alternative Benefit Plan Population Name: Enhanced Alternative Benefit Plan

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Infants and Children under Age 19	Voluntary	X
+	Former Foster Care Children	Voluntary	X
+	Extended Medicaid due to Spousal Support Collections	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Deemed Newborns	Voluntary	X
+	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Voluntary	X
+	Aged, Blind and Disabled Individuals in 209(b) States	Voluntary	X
+	SSI Beneficiaries	Voluntary	X
+	Individuals Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Voluntary	X
+	Certain Individuals Needing Treatment for Breast or Cervical Cancer	Voluntary	X

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

Targeting Criteria (select all that apply):

☒ Income Standard.

Income Standard:

◉ Income standard is used to target households with income at or below the standard.

○ Income standard is used to target households with income above the standard.

The income standard is as follows:

○ A percentage:

◉ A specific amount

The standard is as follows:

◉ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Other basis for income standard

Statewide standard

	Household Size	Income Standard	
+	1	233	X
+	2	289	X
+	3	365	X
+	4	439	X
+	5	515	X
+	6	590	X
+	7	666	X
+	8	741	X
+	9	816	X
+	10	892	X

Additional incremental amount?

◉ Yes ○ No

Increment amount $ 75

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

Individuals with health care needs that cannot be met with the Basic ABP
Pregnant Women within the income limits above are eligible for full Medicaid
Pregnant Women with income greater than those listed above, but below 133% FPL are eligible for pregnancy-related services
Children 0 - 6 in families with income under 142% FPL are eligible for Medicaid
Children 6 - 18 in families with income under 133% FPL are eligible for Medicaid
Deemed Newborns - Automatic Eligibility
Former Foster Care Children - Automatic Eligibility
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care - Automatic Eligibility
Extended Medicaid due to Spousal Support Collections - Continue with previous eligibility

Alternative Benefit Plan

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

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

PRA Disclosure Statement

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

V.20130724

Alternative Benefit Plan

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

Attachment 3.1-C- N

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

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

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

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

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

a) Enrollment is voluntary;

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

c) What the process is for disenrolling.

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

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

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

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

☐ Letter

☐ Email

☒ Other:

Describe:

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that includes informing each eligible individual of the available benefit options. The Department will inform each individual in a covered population that enrollment in the Enhanced Benchmark Benefit Package is voluntary (i.e. participants may opt-in), and that such individuals may opt out of the Enhanced Benchmark Benefit Package at any time and regain immediate eligibility for Medicaid benefits under the State plan.

The Department will provide such information, in writing, to covered populations, at the following opportunities:
• Initial application for assistance;
• Notice of eligibility determination; and
• Selection of primary care case manager.

As part of the application process, the applicant will fill out a "Rights and Responsibility" page that includes areas for them to confirm that they have chosen their plan.
http://healthandwelfare.idaho.gov/Portals/0/FoodCashAssistance/ApplicationForAssistance.pdf

The Participant handbook, "Idaho Health Plan Coverage," tells the participant how they can enroll in another plan. There is also a document entitled Medicaid Comparison Benefits. Both documents are available on line at http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx, and are also available in hard copy upon request from any Health and Welfare office.

Alternative Benefit Plan

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

An attachment is submitted.

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

The state informs participants of their benefit plan options at the time of enrollment, at redetermination, and upon request.

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

The Department has an "Any Door" policy. The participant can notify their local eligibility office, their regional office, their Healthy Connections provider, or the Medicaid Central Office and obtain information about changing plans.

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

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

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

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

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

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other:

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

☒ Copy of correspondence sent to the individual.

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

☐ Other:

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

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

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.20130807

Alternative Benefit Plan

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

Attachment 3.1-C- N

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

Select one of the following:

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

Name of benefit package: Enhanced Alternative Benefit Plan

Selection of the Section 1937 Coverage Option

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

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

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

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

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

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

Selection of Base Benchmark Plan

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

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

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

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

PRA Disclosure Statement

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

V.20130801

Alternative Benefit Plan

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

Attachment 3.1-C- N

Alternative Benefit Plan Cost-Sharing	ABP4

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

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

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

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148

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

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:

Outpatient Facility Fee (e.g., ASC)

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Ambulatory Surgery Center (ASC);

Selected services require prior authorization.

Benefit Provided:

Outpatient Surgery Physician/ Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Selected services require prior authorization.

Benefit Provided:

Urgent Care Centers or Facilities

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Remove

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

Benefit Provided:

Chiropractic Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

6 Visits

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 review for medical necessity and prior authorize chiropractic services after the initial six visits per year.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Renal Dialysis

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

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

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Enterostomal Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Home IV Therapy

Source: Base Benchmark Small Group

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Hospice

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

Add

Alternative Benefit Plan

■ Essential Health Benefit 2: Emergency services — Collapse All ☐

Benefit Provided: Emergency Room Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Emergency Transportation/Ambulance

Source: Base Benchmark Small Group

Remove

Authorization: Retroactive Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

■ Essential Health Benefit 3: Hospitalization Collapse All ☐

Benefit Provided:
Inpatient Hospital Services (e.g., Hospital Stay)

Source:
Base Benchmark Small Group

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

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

Remove

Add

■ 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;
Beneficiaries in the optional pregnant women group may receive EHB and other 1937 services that are pregnancy related as described below:
Idaho covers services that are necessary for the health of the pregnant woman and fetus, or that have become necessary because of the woman having been pregnant and services for other conditions that might complicate the pregnancy. Coverage includes prenatal care, delivery, postpartum care, and family planning services. This coverage includes services for the mother or fetus for other conditions that might complicate the pregnancy include those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus. Pregnancy related services are covered for a postpartum period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.
Idaho does not cover services for pregnant women that are medically contraindicated during pregnancy or elective procedures for conditions that do not threaten the health of the pregnant woman, the carrying of the fetus to full term, or the safe delivery of the fetus.

Based on the benefits provided this group does not meet Minimum Essential Coverage under section 5000A(f)(1)(E) of the Internal Revenue Code on 1986.

Benefit Provided:
Delivery and All Inpatient Services-Maternity Care

Source:
Base Benchmark Small Group

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.

Remove

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.

Benefit Provided:
Substance Abuse Disorder Inpatient Services

Source:
Secretary-Approved Other

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:

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:
Community-Based Rehabilitation Services

Source:
Secretary-Approved Other

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

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

- 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:

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:

Benefit Provided:
MH/BH Outpatient: ECT 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 Services:Med Management

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Add

■ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

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

Coverage that exceeds the minimum requirements or other:

The 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

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

■ Essential Health Benefit 8: Laboratory services — Collapse All ☐

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

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Add

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

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

Benefit Provided: Preventive Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

The 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.

- 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.

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.

Remove

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

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:	
Prior Authorization	Selected Public Employee/Commercial Plan	Remove

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:

Major Dental Care - Child

Selected services require prior authorization.

Add

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted:

Residential Treatment

Source:
Base Benchmark

Remove

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

The Department substitutes Community-Based Rehabilitation Services 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.

This is an IMD.

Base Benchmark Benefit that was Substituted:

Partial Hospitalization

Source:
Base Benchmark

Remove

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

The Department substitutes Community-Based Rehabilitation Services and Partial Care Treatment for Partial Hospitalization (part of the EHB Mental/Behavioral Health Outpatient services).

This is an IMD.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Non-Emergency Care When Traveling Outside the U.S.

Source:
Base Benchmark

Remove

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

Non-covered in accordance with federal statute.

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.

Remove

Other 1937 Benefit Provided:

Private-Duty Nursing

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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:

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:

Licensed Midwife

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services include antepartem, intrapartum, up to six (6) weeks of postpartum maternity care, and up to six weeks of newborn care.

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: 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:
Orthodontia: Child

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:
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:
Optometrist and Ophthalmologist Services: Adults

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
One pair glasses or contacts post cataract surgery

Duration Limit:
None

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 service s 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.

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

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:

• 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.

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.

Remove

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).

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 .

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 fiel.d 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.

• 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

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.

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.

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)):

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

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,

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.

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.

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.

Remove

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

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Nursing facility services; 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:
Durable Medical Equipment

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Home health care services; 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:
Podiatrist Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

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

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 is 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]

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.

~ 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))

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

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

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.

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

Remove

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

- 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

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

Collapse All ☐

PRA Disclosure Statement

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

V.20130808

Alternative Benefit Plan

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

Attachment 3.1-C- N

Benefits Assurances — ABP7

EPSDT Assurances

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

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Behavioral health and dental services are provided through PAHP contracts which require the contractor to provide EPSDT services. Participants maintain their right to appeal through through the Department. All EPSDT medical/surgical and developmental disability services are provided through fee-for-service. Department policy is that any decisions for the payment or prior authorization of services for a child, under the age of twenty-one (21), be reviewed as an EPSDT request.

Prescription Drug Coverage Assurances

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

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

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

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

Alternative Benefit Plan

Other Benefit Assurances

- ☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- ☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20130807

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:

(•) 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. No

PAHP Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan: No

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):

V.20130718

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.

Idaho's PCCM program is operated in accordance with 42 CFR 438, and is an ongoing program with no new implementation outreach activities are anticipated at this time. However, at the time of enrollment, all new participants are informed about PCCM, and given the opportunity to choose their primary care provider. Information for participants about the PCCM program is found in the Idaho Health Plan Coverage booklet which is available on-line. Department representatives visit physicians and non-physician practitioners and keep them informed about Idaho's PCCM program.

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. No

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

PCCM service delivery is provided on less than a statewide basis. No

PCCM Payments

Specify how payment for services is handled:

◉ Per member/per month case management fee paid to PCCM provider.

○ Other:

Additional Information: PCCM (Optional)

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

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Except for the Dental and the Behavioral Health services, the Enhanced Alternative Benefit Plan is furnished on a fee-for-service basis for all participants consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

Additional Information: Fee-For-Service (Optional)

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

V.20130718

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.

Stakeholder meetings were held in 2012, and continuous feedback solicited through the Department's website. In 2013, Idaho sent notification regarding implementation of the managed care contract was sent to all participants and providers. The contract requires that the Contractor shall have a Communication Plan that includes a plan to communicate with Members, providers and stakeholders, including Member service and provider service call centers and Member and provider handbooks. Member handbooks were mailed in August of 2013, prior to implementation.

PAHP: Prepaid Ambulatory Health Plan

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

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

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

Identify the date the managed care program was approved by CMS: June 24, 2013

Alternative Benefit Plan

Describe program below:

The Department covers community-based outpatient behavioral health services through a PAHP contract. The implementation date of the managed care delivery system was September 1, 2013.

The Department contracted with a single, statewide managed care entity, United Behavioral Health, dba Optum/Idaho, who meets the requirements of a PAHP (as defined in 42 CFR § 438.8(b)). Optum manages a network of providers across the state in order to administer behavioral health services to eligible Medicaid members.

The Department has designated the Division of Medicaid to oversee the Idaho Behavioral Health Plan to assure compliance with federal financing requirements. Medicaid provides for an IDHW Contract Manager to lead ongoing contract administration and contract performance monitoring with overall responsibility for the management of all aspects of the contract.

Through the implementation of a managed care system under a 1915(b) waiver, Idaho seeks to achieve the following goals:
Short Term Goals:

* Enrollment of sufficient number of competent professionals to deliver core services; Successful claims processing; Improved identification of Members who meet program qualifications for behavioral health treatment; and Successful transition process for both providers of services (agencies and individual practitioners) and Members.

Intermediate Goals:

* Effective communications between the IDHW, Contractor and all other stakeholders; Increase in number of Members who receive behavioral health care treatment that accurately matches their behavioral health care needs; Implementation of utilization management and quality assurance processes that result in improved operations/services and improved payment approaches; and Improved coordination with all other treatment providers and programs that Members are involved with, specifically, the Healthy Connections program and the Health Home program.

Long Term Goals:

* Positive outcomes for Members that result in Members' recovery and/or resiliency; Decreased inappropriate use of higher cost services (hospital, emergency departments, crisis); Administrative efficiencies realized that include greater reliance on technology, cost-effective management of the network and of services, and decrease in waste and fraud; and Greater satisfaction with treatment and support services among Members and greater satisfaction for agencies and practitioners in the administration of the services.

Additional Information: PAHP (Optional)

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

PRA Disclosure Statement

Alternative Benefit Plan

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

Attachment 3.1-C- N

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid-covered services provided to individuals enrolled in the Enhanced Alternative Benefit Plan (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the Enhanced Alternative Benefit Plan (subject to any nominal Medicaid co-payment) for eligible individuals in employer-based cost-effective group health plans.

When coverage for Medicaid-eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan.

Cost effectiveness is determined by comparing the total amount paid by the primary insurance company to the premiums and deductible. If the primary insurance has paid more than the premiums and deductible, the case is cost effective. If the primary insurance has paid less than the premiums and deductible, the case is NOT cost effective.

The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums. **No**

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

Alternative Benefit Plan

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

Attachment 3.1-C- N

General Assurances — ABP10

Economy and Efficiency of Plans

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

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

Compliance with the Law

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

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

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

PRA Disclosure Statement

V.20130807

Alternative Benefit Plan

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

Attachment 3.1-C- N

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

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

An attachment is submitted.

V.20130807