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## **Table of Contents**

**State/Territory Name: Idaho**

**State Plan Amendment (SPA) #: 14-001**

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  
**Centers of Medicaid and CHIP Services**

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

**APR 17 2014**

**RE: Idaho State Plan Amendment (SPA) Transmittal Number 14-001**


Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 14-001. This transmittal incorporates tobacco cessation counseling for pregnant woman into the Medicaid State Plan in accordance with section 4107 Affordable Care Act.

This SPA is approved effective January 1, 2014.

If you have any additional questions or require any further assistance, please contact me or have your staff contact Maria Garza at (206) 615-2542 or [maria.garza@cms.hhs.gov](mailto:maria.garza@cms.hhs.gov).

Sincerely,

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

cc:  
Denise Chuckovich, Deputy Director  
Paul Leary, Medicaid Benefits Administrator

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:  
**14-001**

2. STATE  
**IDAHO**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE  
**January 1, 2014**

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1937(b)(5) of the Act

**4107 of ACA (P&I)**

7. FEDERAL BUDGET IMPACT:

FFY 2014: \$0 (zero dollars)

FFY 2015: \$0 (zero dollars)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, page 5

- Attachment 3.1-A, Standard State Plan pages ~~54 and 21~~ (P&I)  
**Attachment 3.1-A, page 2**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION (P&I)  
OR ATTACHMENT (*If Applicable*): Attachment 3.1-A, page 5

- Attachment 3.1-A, Standard State Plan pages ~~54 and 21~~  
**Attachment 3.1-A, page 2**

10. SUBJECT OF AMENDMENT:

(P&I)

~~Provision of tobacco cessation products and counseling to all Medicaid participants. This change will also be reflected in the State's Alternative Benefit Plan SPA for the current Basic, Enhanced and MMCP pages.~~ This submission adds clarification language to the preprint page inadvertently omitted TCC-PW under 4d

11. GOVERNOR'S REVIEW (*Check One*):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

**PAUL J. LEARY**

14. TITLE:

**Administrator**

15. DATE SUBMITTED:

**1-21-14**

16. RETURN TO:

Paul J. Leary, Administrator  
Idaho Department of Health and Welfare  
Division of Medicaid  
PO Box 83720  
Boise ID 83720-0009

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: **1-21-14**

18. DATE APPROVED: **04/17/2014**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

**January 1, 2014**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

**Carol J.C. Peverly**

22. TITLE:

**Associate Regional Administrator  
Division of Medicaid &  
Children's Health**

23. REMARKS:

**3/11/14- State authorizes P&I change to box 6,8,9 and 10**

**4/02/14- State authorizes P&I change to box 8 and 9**

**4/16/14- State authorizes P&I change to box 6,8,9,10**

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES  
PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.  
Provided:     /   /   No limitations           / X /   With limitations\*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.\*
- 4.c. Family planning services and supplies for individuals of child—bearing age.  
Provided:     /   /   No limitations           / X /   With limitations\*
- 4.d. Tobacco Cessation Counseling Services for Pregnant Women.  
Provided:     /   /   No limitations           / X /   With limitations\*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.  
Provided:     /   /   No limitations           / X /   With limitations\*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).  
Provided:     /   /   No limitations           / X /   With limitations\*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.  
Provided:     /   /   No limitations           /   /   With limitations\*  
/ X / Not Provided

\* Description provided on attachment



**IDAHO MEDICAID  
STANDARD STATE PLAN**

Revision: HCFA—PM—85—3 (BERC)

Attachment 3.1-A

May 1985

OMB No: 0938-0193

State: IDAHO

**Attachment 3.1-A - AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL  
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.
- |      |               |     |                |     |                   |
|------|---------------|-----|----------------|-----|-------------------|
| / /  | Provided:     | / / | No limitations | / / | With limitations* |
| /X / | Not provided. |     |                |     |                   |
- b. Dentures.
- |      |               |     |                |     |                   |
|------|---------------|-----|----------------|-----|-------------------|
| / /  | Provided:     | / / | No limitations | / / | With limitations* |
| /X / | Not provided. |     |                |     |                   |
- c. Prosthetic devices.
- |      |               |     |                |     |                   |
|------|---------------|-----|----------------|-----|-------------------|
| / /  | Provided:     | / / | No limitations | / / | With limitations* |
| /X / | Not provided. |     |                |     |                   |
- d. Eyeglasses.
- |      |               |     |                |     |                   |
|------|---------------|-----|----------------|-----|-------------------|
| / /  | Provided:     | / / | No limitations | / / | With limitations* |
| /X / | Not provided. |     |                |     |                   |
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.
- a. Diagnostic services.
- |      |               |     |                |     |                   |
|------|---------------|-----|----------------|-----|-------------------|
| / /  | Provided:     | / / | No limitations | / / | With limitations* |
| /X / | Not provided. |     |                |     |                   |