Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 16-0010

This file contains the following documents in the order listed:

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

March 10, 2017

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

RE: Idaho State Plan Amendment (SPA) Transmittal Number 16-0010

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 16-0010. This SPA modifies Idaho's Medicare-Medicaid Coordinated Plan (MMCP) Alternative Benefit Plan (ABP) to reflect the MMCP's geographic service area reduction changes. The geographic service area availability of the MMCP is reduced from forty-two (42) of Idaho's forty-four (44) counties, to twenty-two (22) of forty-four (44) counties.

The enclosed SPA is approved with an effective date of January 1, 2017 as requested by the state.

If you have any questions concerning this SPA or require further assistance, please contact me or have your staff contact Walter Neal at walter.neal@cms.hhs.gov or (206) 615-2330.

Sincerely,

Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS

[redacted]

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-16-0010

Proposed Effective Date

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

Federal Statute/Regulation Citation

Section 2302 of the Affordable Care Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2017	$ 0.00
Second Year	2018	$ 0.00

Subject of Amendment

The purpose of this ABP SPA is to ensure the applicable sections of the ABP reflect the service area reduction of the Idaho Medicare-Medicaid Coordinated Plan (MMCP). The Health Plan that administers the MMCP received approval from CMS to reduce the service area of this Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) to 22 of Idaho's 44 counties effective January 1, 2017.

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:	**Dec 19, 2016**
Submit Date:	**Dec 19, 2016**

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- M

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

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

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

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

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

Enrollment is available for all individuals in these eligibility group(s).

Geographic Area

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

Select a method of geographic variation:

- (•) By county.
- ( ) By region.
- ( ) By city or town.
- ( ) Other geographic area.

Specify counties:

MMCP-ABP is available in 22 of 44 counties including the following: Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Clark, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, and Twin Falls

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- M

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

ABP2b

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

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

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

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

a) Enrollment is voluntary;

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

c) What the process is for disenrolling.

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

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

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

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

☒ Letter

☐ Email

☐ Other:

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

An attachment is submitted.

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

The state informs participants of their benefit plan options at the time of enrollment and the Plan sends them a summary of benefits annually.

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

Individuals can notify the Plan directly or through any Health and Welfare office or they can call the Department's information line at 211. Information is also available on line.

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

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

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

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

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

- ☐ In the eligibility system.
- ☐ In the hard copy of the case record.
- ☒ Other:

Describe:

Information is kept:
- In the MMIS , and
- By the Health Plan

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

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V.20130807

Alternative Benefit Plan

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

Attachment 3.1-C- M

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

Select one of the following:

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

Name of benefit package: Medicare/Medicaid Coordinated ABP

Selection of the Section 1937 Coverage Option

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

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

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

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

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

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

Selection of Base Benchmark Plan

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

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

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

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

PRA Disclosure Statement

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

V.20130801

Alternative Benefit Plan

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

Attachment 3.1-C- M

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
OMB Expiration date: 10/31/2014

Attachment 3.1-C- M

Benefits Description ABP5

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

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

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

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

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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

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

"Secretary-Approved"

Alternative Benefit Plan

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

Benefit Provided: Primary Care Visit to Treat an Injury or Illness

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Specialist Visit

Source: Base Benchmark Small Group — Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Manual manipulation of the spine to correct subluxation

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

See "other 1937" benefits for additional services.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Renal Dialysis

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

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

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Enterostomal Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Home IV Therapy

Source: Base Benchmark Small Group

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Hospice

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Emergency Transportation/Ambulance

Source: Base Benchmark Small Group — Remove

Authorization: Retroactive Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

■ Essential Health Benefit 3: Hospitalization — Collapse All ☐

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

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

Amount Limit: None
Duration Limit: None

Scope Limit: None

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

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

Selected services require 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

Alternative Benefit Plan

Scope Limit:

None

Remove

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

Add

Alternative Benefit Plan

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

Benefit Provided: Prenatal and Postnatal care

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Delivery and All Inpatient Services-Maternity Care

Source: Base Benchmark Small Group — Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Add

Alternative Benefit Plan

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

Collapse All ☐

Benefit Provided: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: MH/BH Inpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Mental Health/Behavioral Health Inpatient Services.

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

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

Services are not provided in an IMD.

Alternative Benefit Plan

Benefit Provided:
MH/BH Outpatient Services

Source:
Secretary-Approved Other

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:

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

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

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

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

Benefit Provided:
Substance Abuse Disorder Inpatient Services

Source:
Secretary-Approved Other

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

The substance use inpatient authorization requirements were created to ensure that payments are consistent with efficiency, economy, and quality of care and that utilization management requirements for inpatient

mental health services found in 42 CFR 456.170-181 are met.

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

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

Services are not provided in an IMD.

Remove

Benefit Provided:

Community-Based Rehabilitation Services

Source:

Secretary-Approved Other

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

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

- Interventions for psychiatric symptomatology will use an active, assertive outreach approach 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

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

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

Alternative Benefit Plan

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

Benefit Provided: Home Health Care Services

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: Outpatient Rehabilitation Services: PT, OT, SLP

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

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:

Up to 20 visits per year of any combination of OT, PT, or SLP rehabilitation and habilitation per year.

All services require PA.

See "other 1937" benefits for additional services.

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

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 Participant's home.

Remove

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

Benefit Provided:

Skilled Nursing Facility

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Skilled Nursing Facility services for rehabilitation.

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

See "Other 1937 Benefits" for services in excess of the Base Benchmark limit of 30 days per year.

Benefit Provided:

Outpatient Habilitation: OT, PT, SLP Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

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

Up to 20 visits per year of any combination of OT, PT, or SLP rehabilitation and habilitation per year.

All services require PA.

See "other 1937" benefits for additional services.

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

Add

Alternative Benefit Plan

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

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

Benefit Provided: Preventive Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

The MMCP- ABP will provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for 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: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Diabetes Education

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

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

Benefit Provided:
Tobacco Cessation Counseling

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Add

Alternative Benefit Plan

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

Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Secretary-Approved Other

Remove

Authorization:
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:
This plan is targeted for adults who are on Medicare. No children have been enrolled.

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 PsychoSocial Rehabilitation Services 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.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered Collapse All ☐

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

Source: Base Benchmark

Remove

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

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

Source: Base Benchmark

Remove

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

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

Source: Base Benchmark

Remove

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

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

Source: Base Benchmark

Remove

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

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

Source: Base Benchmark

Remove

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

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

Source: Base Benchmark

Alternative Benefit Plan

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

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

Remove

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Medicaid State Plan EPSDT Benefits

Source:
Base Benchmark

Remove

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

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

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.

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

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

Other 1937 Benefit Provided:
Hospice

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: 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.

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

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

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

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.

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; 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.

Remove

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

PCS are furnished 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.

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).

Other 1937 Benefit Provided:

Outpatient Rehab: OT, PT, and SLP

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:
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: Rehabilitation and Habilitation Services

MMCP-ABP covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark aggregate 20 visit limit when medically necessary.

Other 1937 Benefit Provided:
ICF/IID

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Services in an intermediate care facility for 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:
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

Remove

Other:

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

Prescription Drugs: In excess of Base Benchmark

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

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes the following Medicare excluded or otherwise restricted drugs or classes of drugs.

Lipase inhibitors subject to Prior Authorization.

Prescription Cough & Cold symptomatic relief.

Legend Therapeutic Vitamins which may include:
- Injectable Vitamin B12;
- Vitamin K and analogues;
- Legend folic acid;
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or, without additional ingredients; and
- Legend Vitamin D and analogues.

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

Additional Covered Drug Products. Additional drug products will be covered as follows:
- Legend prenatal vitamins for pregnant or lactating women;
- Legend folic acid;
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and
- Legend Vitamin D and analogues.

Prescriptions for non-legend products will be covered as follows:
- Permethrin.

Other 1937 Benefit Provided:

Home Health Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Remove

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 MMCP-ABP contractor covers medically necessary services in accordance with Medicare criteria.

Coverage includes:
- Part-time or intermittent skilled nursing,
- Home health aide services,
- Physical, therapy,
- Occupational therapy,
- Speech therapy
- Medical and social services and
- Medical equipment and supplies.

Other 1937 Benefit Provided:

Nursing Facility: Rehabilitation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

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 (SNF)

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

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

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

Other 1937 Benefit Provided:
Podiatrist Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

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

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

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

Routine foot care is not covered.

Other 1937 Benefit Provided:
Diabetes Education

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

The Base Benchmark covers up to $500 (approximately 5 hours) per year for diabetes education. The MMCP-ABP covers services up to the Medicare allowed of 10 hours per year.

Other 1937 Benefit Provided:
Bariatric Surgery

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Remove

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

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

Other 1937 Benefit Provided:

Outpatient Habilitation: OT, PT, and SLP Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

20 visits/year

Duration Limit:

None

Scope Limit:

None

Other:

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

Services in excess of the Base Benchmark: Habilitation Services;

MMCP covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark aggregate 20 visit limit when prior authorized based on medical necessity.

Other 1937 Benefit Provided:

Chiropractic Care

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Chiropractic services include manual manipulation of the spine to treat a subluxation condition.

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

Remove

Other 1937 Benefit Provided:

Audiology

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Other 1937 Benefit Provided:

Targeted 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.

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.

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 ☐

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V.20130808

Alternative Benefit Plan

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

Attachment 3.1-C- M

Benefits Assurances — ABP7

EPSDT Assurances

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

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

Prescription Drug Coverage Assurances

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

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

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

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

Other Benefit Assurances

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

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

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

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

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

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

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

Alternative Benefit Plan

☑ 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).

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Alternative Benefit Plan

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

Attachment 3.1-C- M

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 program was authorized under 1937 authority. The 2014 Affordable Care Act replaces in whole the previously authorized program under the 2005 Deficit Reduction Act authority. The MCO agreement replaced the previously established PAHP agreement for the Idaho Medicare-Medicaid Coordinated Plan (MMCP) effective July 1, 2014. Idaho Medicaid has conducted over a dozen web-based seminars from April 2012 forward to engage stakeholders in the development and implementation of changes to the MMCP. Medicaid continues to keep participants, providers, and other stakeholders apprised of implementation activities via webinars, website postings, and member and provider notifications.

MCO: Managed Care Organization

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 managed care organization (MCO) consistent with applicable managed care requirements (42 CFR Part 438, and sections 1903(m), 1932 and 1937 of the Social Security Act).

MCO Procurement or Selection Method

Indicate the method used to select MCOs:

- ○ Competitive procurement method (RFP, RFA).
- ◉ Other procurement/selection method.

Alternative Benefit Plan

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

Any willing MAO may apply with the State Medicaid agency to become a Medicaid provider.

Other MCO-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the managed care organization. No

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

	Benefit/service	Description of how the benefit/service will be provided	
+			x

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

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

- (•) MCO service delivery is available only in designated counties.
- ( ) MCO service delivery is available only in designated regions.
- ( ) MCO service delivery is available only in designated cities and municipalities.
- ( ) MCO service delivery is available in some other geographic area (geographic area must not be smaller than a zip code).

Specify counties:

Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Clark, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, and Twin Falls

MCO Participation Exclusions

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

Select all that apply:

- [ ] Individuals with other medical insurance.
- [ ] Individuals eligible for less than three months.
- [ ] Individuals in a retroactive period of Medicaid eligibility.
- [x] Other:

Describe:

Individuals under age 21. Individuals whose Medicare eligibility is due to end-stage renal disease (ESRD).

General MCO Participation Requirements

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

- ( ) Mandatory participation.
- (•) Voluntary participation. Indicate the method for effectuating enrollment:

- (●) Affirmative selection of MCO.
- ( ) State enrolls individual in MCO and permits disenrollment.
- ( ) Other:

Additional Information: MCO (Optional)

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

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V.20130718

Alternative Benefit Plan

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

Attachment 3.1-C- M

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

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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Alternative Benefit Plan

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

Attachment 3.1-C- M

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- M

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