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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 24-0009

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

March 25, 2026

Sasha O'Connell
Deputy Director
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 8320
Boise, ID 83720-0009

Re: Idaho State Plan Amendment (SPA) 24-0009

Dear Deputy Director O'Connell:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0009. This SPA revises Idaho's Enhanced Alternative Benefit Plan (ABP) to modify provider qualifications in Crisis Intervention, extend Family Support services up to age twenty-one, expand the definition of benefits in Outpatient Services to include Transcranial Magnetic Stimulation, update Peer Support benefits and provider qualifications to include Recovery Coaches, add Residential Treatment for substance use disorder and behavioral health, and shift Respite from Section 1915(i) authority to the ABP.

While both the Yes Empowerment Services 1915(i) state plan HCBS benefit and this ABP are active, the state has assured CMS that mechanisms are in place to prevent duplication of services and payment, per 42 CFR Part 433, Subpart F.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that Idaho Medicaid SPA 24-0009 was approved on March 24, 2026, with an effective date of October 1, 2024.

If you have any questions, please contact Courtenay Savage at (312) 353-3721 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

Nicole McKnight
On Behalf of Courtney Miller, MCOG Director

Enclosures

cc: Charles Beal

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Idaho**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

ID-24-0009

Proposed Effective Date

10/01/2024 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1905 of the Social Security Act; Section 1937 of the Social Security Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2025	$ 15338274.00
Second Year	2026	$ 19627467.00

Subject of Amendment

Amendment to the State Plan to add and modify benefits in the Idaho Medicaid State Plan Basic and Enhanced Alternative Benefit Plans (ABPs).

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:	**Charles Beal**
Last Revision Date:	**Oct 4, 2024**
Submit Date:	**Oct 4, 2024**

Alternative Benefit Plan

State Name: Idaho | Attachment 3.1-L- N | OMB Control Number: 0938-1148

Transmittal Number: ID - 24 - 0009

Benefits Description — ABP5

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

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

☑ 1. Essential Health Benefit: 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 prior authorization.

Benefit Provided: Other Practitioner Office 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 prior authorization.

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

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

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:

Chiropractic Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

Six (6) visits

Duration Limit:

None

Scope Limit:

Coverage only for treatment involving manipulation of the spine to correct a subluxation condition.

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

The State Medicaid Agency will review for medical necessity and prior authorize chiropractic services after the initial six (6) 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

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: 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

Remove

Alternative Benefit Plan

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:
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 twenty-one (21) is covered.

As soon as they begin to receive this benefit, participants are transitioned to this Enhanced ABP.

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: 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: 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

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Remove

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

Source: Base Benchmark Small Group

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 State Medicaid Agency or its contractor after three (3) days, or in four (4) days if the participant has had a cesarean section.

Selected services require prior authorization.

Remove

Benefit Provided: Inpatient Physician and Surgical Services

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 prior authorization.

Remove

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:

Add

Alternative Benefit Plan

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

Remove

Benefit Provided: Prenatal and Postnatal 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:

SSee "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.

Remove

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

Alternative Benefit Plan

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

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

Add

Alternative Benefit Plan

Collapse All ☐

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

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Substance Use Disorder Outpatient Services

Source: Base Benchmark Small Group

Authorization: None

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:

Provider Qualifications - Qualified Providers:
1) Licensed physician
2) Advanced Practice Registered 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's degree, a Certification or Licensing in their field, and meet requirements of the State Medicaid Agency.
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

Remove

Benefit Provided: MH/BH Inpatient Services

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:

Mental Health/Behavioral Health Inpatient Services.
Services are not provided in an IMD.

Alternative Benefit Plan

Remove

Benefit Provided:
Substance Use 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 Department covers Substance Use 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.

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 in amount, duration or scope.

A distinct and organized intensive ambulatory treatment service offering less than twenty-four (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.

Provider Qualifications
Partial Care treatment may be provided by one of the following contracted licensed or certified professionals within the scope of their practice:
1) Licensed physician

2) Advanced Practice Registered 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's degree and are Licensed Social Workers
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
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: Psychotherapy: Individual, Family, and Group

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:

Outpatient psychotherapy services are in-person, non-electronic services (except when telehealth is provided in accordance with board regulations), and are used to treat mental health conditions and substance use disorders. Family and Individual Psychotherapy may be delivered in a home or community-based setting.

Remove

Benefit Provided: MH/BH Outpatient Services: Neuromodulation

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:

Inclusive of treatments such as Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS).

Remove

Benefit Provided:
Medication Management

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:

Provider Qualifications
Services may be provided by one of the following contracted professionals within the scope of their practice:
1) Licensed physician
2) Licensed non-physician practitioner with prescriptive authority

Remove

Benefit Provided:
Intensive Outpatient Program, MH and SUDs

Source:
Base Benchmark Small Group

Authorization:
None

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
IOP services do not include overnight housing.

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

An Intensive Outpatient Program (IOP) can be used to treat mental health conditions or substance use disorders, or can specialize in the treatment of co-occurring mental health and substance-related disorders. IOP is a structured program for participants whose symptoms result in significant personal distress and/or significant psychosocial and environmental issues. IOP provides not only behavioral health treatment, but also the opportunity to practice new skills. Programs for adolescents are offered separately from programs for adults, and each program and its staff must meet the certification and credentialing criteria of the State Medicaid Agency. In compliance with EPSDT, this service is covered for children through the month of their twenty-first (21st) birthday when medically necessary.

IOP is appropriate for participants who are experiencing symptoms that can be addressed and managed in a level of care that is less intensive than psychiatric hospitalization but that require a higher level of care than routine outpatient services. The program may function as a step-down option from psychiatric hospitalization, partial hospitalization, or residential treatment, and may also be used to prevent or minimize the need for a more intensive level of treatment.

IOP–Mental Health occurs at a minimum of three (3) days per week, maintaining at least nine (9) hours of service for adults and at least six (6) hours of service for adolescents. IOP–SUDs maintains nine (9) to

nineteen (19) hours of service weekly for adults and six (6) to nineteen (19) hours of service for adolescents. Services are expected to be maintained at this level throughout the duration of the program. However, services may be authorized at a less intense level for fewer hours per week as the participant moves toward discharge until the participant can be safely and appropriately transitioned back into a less intensive level of outpatient care.

IOP services may include any of the following:
• Individual, group, and family psychotherapy and education focused on recovery
• Evidence-informed practices such as group therapy, cognitive behavioral therapy (CBT), motivational interviewing, and multidimensional family therapy
• Psychiatric evaluations and medication management
• Substance use screening and monitoring, if appropriate
• Transition management and discharge planning
• Twenty-four (24) hour crisis coverage
• Initial and ongoing risk assessments

Due to the non-residential nature of the program, IOP services are commonly provided during evenings and on weekends. Because IOP programs have such a different approach and intensity, they are not typically designed to be used for extended duration; instead they rely on an integrated approach using high-frequency contact to increase functioning, monitor and maintain stability, and support recovery. Following the participant's admission to IOP, it is not appropriate for other behavioral health providers to provide services to the participant or bill for services outside the program, with the exception of psychiatric services and medication management. All other services are included in the IOP's per diem rate.

Provider Qualifications
IOP services may be provided by the following contracted professionals within the scope of their practice: 1) Licensed physician 2) Advanced Practice Registered Nurse 3) Physician Assistant 4) Licensed Social Worker 5) Licensed Counselor 6) Licensed Marriage and Family Therapist 7) Paraprofessionals who hold at least a Bachelor's degree and a current credential from the Psychiatric Rehabilitation Association (i.e., a certificate or certification in psychiatric rehabilitation based upon the primary population with whom the provider works, in accordance with the requirements set by the PRA), and who meet requirements of the State Medicaid Agency 8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses) 9) Registered Nurse

The IOP provider is responsible for coordination of care with the participant's primary care provider (PCP) and other behavioral health providers.

Benefit Provided: Psychological/Neuropsychological Testing

Source: Base Benchmark Small Group

Remove

Authorization: None

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:

Provider Qualifications

The provider's professional training and licensure must include any of the following:
1) A doctoral-level psychologist who is licensed to practice independently, and demonstrates sufficient training and experience.
2) A psychometrist or psychometrician who administers and scores psychological tests under the supervision of a licensed, doctoral-level psychologist, and whose services are billed by the supervising psychologist.
-The supervising psychologist must have face-to-face contact with the participant at intake and during the feedback session.
-The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.
3) A master's-degreed behavioral health professional whose licensure specifically allows for provision of psychological testing services.
-The master's-degreed provider has professional expertise in the types of tests/assessments being administered.
-The master's-degreed provider is conducting test administration, scoring and interpretation in accordance with licensing standards and psychological testing professional and ethical standards.

Benefit Provided:
Skills Building/CBRS: Adults

Source:
Secretary-Approved Other

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Limited to adults age eighteen (18) or over who are receiving treatment for a Severe and Persistent Mental Illness (SPMI) or Serious Mental Illness (SMI) and have a functional impairment.

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

The Skills Building/Community Based Rehabilitation Services (CBRS): Adults service focuses on behavioral, social, communication, rehabilitation, and/or basic living skills training to increase a participant's functioning and decrease mental health and/or behavioral symptoms. Skills Building/CBRS addresses an adult's ability to function adaptively in home and community settings. Examples of training areas that may be addressed include self-care, behavior, social decorum, avoidance of exploitation, anger management, budgeting, development of social support networks, and use of community resources.

Delivered pursuant to a written plan of care, Skills Building/CBRS vary in intensity, frequency, and duration in order to support the participant's ability to manage functional difficulties and to realize recovery and resiliency goals.

Skills Building/CBRS is appropriate for adults receiving treatment for a Severe and Persistent Mental Illness (SPMI) or Serious Mental Illness (SMI) when they have been assessed to have at least two (2) significant functional deficits related to the identified SPMI/SMI, and Skills Building/CBRS services are necessary in order for the adult to obtain and/or apply developmentally age-appropriate skills.

The participant's functioning in the following areas will be assessed to determine the training needs to address using Skills Building/CBRS:
• Vocational/educational
• Financial

• Social relationships/support
• Family
• Basic living skills
• Housing
• Community/legal
• Health/medical

Provider Qualifications
Skills Building/CBRS services may be provided by one of the following contracted professionals within the scope of their practice:
1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Paraprofessionals who hold at least a Bachelor's degree and who meet requirements of the State Medicaid Agency
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

Remove

Benefit Provided: Skills Building/CBRS: Children

Source: Secretary-Approved Other

Authorization: Other

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:

In compliance with EPSDT, this service is covered for children through the month of their twenty-first (21st) birthday when medically necessary.

The Skills Building/Community Based Rehabilitation Services (CBRS): Children service focuses on behavioral, social, communication, rehabilitation, and/or basic living skills training to increase a participant's functioning and decrease mental health and/or behavioral symptoms. Skills Building/CBRS addresses the child's ability to function adaptively in home and community settings.

Delivered pursuant to a written plan of care, Skills Building/CBRS vary in intensity, frequency, and duration in order to support the participant's ability to manage functional difficulties and to realize recovery and resiliency goals.

Skills Building/CBRS is appropriate for a child receiving treatment for a SED when the child has been assessed to have at least one (1) significant functional deficit related to the identified SED and Skills Building/CBRS are necessary in order for the child to obtain and/or apply developmentally age-appropriate skills.

The participant's functioning in the following areas will be assessed to determine the training needs to address using Skills Building/CBRS:
• Vocational/educational
• Financial
• Social relationships/support
• Family
• Basic living skills
• Community/legal

Provider Qualifications
Skills Building/CBRS services may be provided by one of the following contracted professionals within the scope of their practice:
1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Paraprofessionals who hold at least a Bachelor's degree and who meet requirements of the State Medicaid Agency
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

Benefit Provided:
Partial Hospitalization, MH and SUDs

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Partial Hospitalization services do not include overnight housing.

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

Partial Hospitalization can be used to treat mental health conditions or substance use disorders, or both; i.e., co-occurring conditions. Partial Hospitalization is a facility-based, structured bundle of services for participants whose symptoms result in severe personal distress and/or significant psychosocial and environmental issues. Partial Hospitalization provides not only behavioral health treatment, but also the opportunity to practice new skills. Services for adolescents are offered separately from services for adults, and each program and its staff must meet the certification and credentialing criteria of the State Medicaid Agency. Services must be delivered under the supervision of a licensed physician. In compliance with EPSDT, this service is covered for children through the month of their twenty-first (21st) birthday when medically necessary.

Partial Hospitalization is appropriate for participants who are experiencing symptoms that can be addressed and managed in a level of care that is less intensive than psychiatric hospitalization but who require a higher level of care than routine outpatient or other intensive services. This service may function as a step-

down option from psychiatric hospitalization or residential treatment, and may also be used to prevent or minimize the need for a more intensive level of treatment. A participant may be admitted to the program when the participant cannot be safely and appropriately treated in a less restrictive level of care.

Partial Hospitalization, MH and SUDs, is delivered a minimum of twenty (20) hours per week for adults or children/adolescents.

Partial Hospitalization may include any of the following component services of the bundle:
• Individual, group, and family psychotherapy and education focused on recovery
• Evidence-informed practices such as group therapy, cognitive behavioral therapy (CBT), motivational interviewing, and multidimensional family therapy
• Psychiatric evaluations and medication management
• Substance use screening and monitoring, if appropriate
• Transition management and discharge planning
• Twenty-four (24) hour crisis coverage, including response and interventions outside of the program setting
• Initial and ongoing risk assessments
• Prescription drugs

Following the participant's admission to Partial Hospitalization, it is not appropriate for other behavioral health providers to provide services to the participant or bill for services outside the program. All component services in the bundle are included in the bundle's per diem rate.

Provider Qualifications
Partial Hospitalization services may be provided by the following contracted professionals within the scope of their practice:
1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
7) Registered Nurse

The Partial Hospitalization provider is responsible for coordination of care with the participant's primary care provider (PCP), IBHP care coordinator, and other behavioral health providers.

Add

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed 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 State Medicaid Agency covers at least the greater of one (1) drug in each U.S. Pharmacopeia (USP) category and class.

Prior Authorization criteria are developed by the State Medicaid Agency'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 are 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.

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

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided: Home Health Care Services: Skilled Nursing
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Skilled Nursing services 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:

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: Twenty (20) visits/yr. (rehabilitative services)
Duration Limit: None
Scope Limit: PT, OT, SLP 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 twenty (20) visits for all occupational therapy (OT), speech-language pathology services (SLP), and physical therapy (PT) combined, and includes both rehabilitation and habilitation. To comply with 45 C.F.R. § 156.115(a)(5)(iii), Idaho Medicaid is establishing separate, equal twenty (20) visit limits each for rehabilitation and habilitation. Services are not provided through a Home Health Agency.

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

Benefit Provided: Habilitation Services
Source: Base Benchmark Small Group
Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
Twenty (20) visits/yr. (habilitative services)

Duration Limit:
None

Scope Limit:
PT, OT, SLP 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.

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 twenty (20) visits for all occupational therapy (OT), speech-language pathology services (SLP), and physical therapy (PT) combined, and includes both rehabilitation and habilitation. To comply with 45 C.F.R. § 156.115(a)(5)(iii), Idaho Medicaid is establishing separate, equal twenty (20) visit limits each for rehabilitation and habilitation. Services are not provided through a Home Health Agency.

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

Remove

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

Scope Limit:
Items that are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of injury, disease, or illness, and are appropriate for use in any setting in which normal life activities take place.

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.

Remove

Benefit Provided:
Skilled Nursing Facility

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
Thirty (30) days per year

Duration Limit:
None

Scope Limit:
Skilled Nursing Facility services for rehabilitation.

Alternative Benefit Plan

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

As soon as they begin to receive this benefit, participants are transitioned to this Enhanced ABP.

See Skilled Nursing Facility in "Other 1937 Benefits" for services in excess of the Base Benchmark.

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided: Diagnostic Test (X-ray and 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, Nuclear Cardiology)
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

☑ 9. Essential Health Benefit: 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).

Remove

Benefit Provided: Preventive Services

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:

The State Medicaid Agency 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).

Remove

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:

Coverage 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 U.S. 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).

Coverage for both children and adults includes an annual preventive health visit and services with "A" and "B" recommendations by the U.S. Preventive Services Task Force.

Remove

Benefit Provided: Diabetes Education

Source: Base Benchmark Small Group

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.

Remove

Benefit Provided: Tobacco Cessation Counseling

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:

Covered in accordance with USPSTF recommendations.

Remove

Benefit Provided: Dietary Counseling

Source: Secretary-Approved Other

Alternative Benefit Plan

Authorization:	Provider Qualifications:
Authorization required in excess of limitation	Selected Public Employee/Commercial Plan
Amount Limit:	Duration Limit:
Two (2) visits per year	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

☑ 10. Essential Health Benefit: 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 through the month of their twenty-first (21st) birthday.

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: Children through the month of their twenty-first (21st) birthday.

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:

Eyeglasses for children through the month of their twenty-first (21st) birthday.

Participants 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 through the month of their twenty-first (21st) birthday.

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 - Children through the month of their twenty-first (21st) birthday.

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

Alternative Benefit 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:

Major Dental Care – Children through the month of their twenty-first (21st) birthday.

Selected services require prior authorization.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

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

☒ 13. 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: Not covered, in accordance with federal statute.

Add

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Remove

Other 1937 Benefit Provided:
Assertive Community Treatment (ACT) (Rehab)

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:
Assertive Community Treatment (ACT) is an evidence-based rehabilitative benefit provided according to 42 C.F.R. § 440.130(d) - Rehabilitative Services. The ACT benefit offers treatment, rehabilitation, and support services using a person-centered, recovery-based approach to individuals who have been diagnosed with severe and persistent mental illness (SPMI).

Individuals receive ACT services from a mobile, multidisciplinary team in community settings. These services are available to the individual twenty-four (24) hours per day. Individuals will have at least one (1) contact with the treatment team every forty-eight (48) hours.

Services:
ACT services will be provided based upon the assessment of an individual's mental, physical, and behavioral condition and history, which will be the basis for establishing the individual's functional deficits and recovery goals.

All medically necessary ACT services to be provided must be documented in a person-centered service plan. Any legal or criminal justice needs must be clearly identified in the goals and objectives. The person-centered service plan must be reviewed, and revised as appropriate, every ninety (90) calendar days.

Specific, measurable, achievable ACT recovery outcomes can include:
• Reduced hospitalizations, re-hospitalization, or use of emergency rooms
• Reduced arrests
• Reduced days of incarceration
• Reduced use of crisis services
• Increased housing stability
• Increased interactions with natural supports
• Increased engagement with employment or education
• Improved quality of life

Collateral contacts will occur with the individual's family, and others significant in their life, that provide a direct benefit to the individual and are conducted in accordance with, and for the purpose of advancing the person-centered service plan; and for coordination of services with other community and medical providers.

Medically necessary ACT Services include:
a. Assessment.
b. Assertive Engagement. Rehabilitative service focused on increasing an individual's engagement with treatment and recovery. It is an active process that includes active listening, shared decision-making, and outreach strategies.

c. Person-centered Planning.
d. Care Coordination.
e. Crisis Intervention.
f. Crisis Response.
g. Community Integration and Re-integration. Rehabilitative service that engages and assists individuals in the restoration of social, interpersonal, and basic living skills impacted by or lost as a result of mental illness which hinder an individual's ability to live in an integrated community setting. It is an active process that includes coordination of services and supports, assisting in transition from a hospital setting, identification or modification of supports, to promote community tenure and manage behavioral and physical health needs.
h. Medication Management.
i. Family Psychoeducation.
j. Integrated Co-occurring Substance Use Disorder (SUD) Treatment. Evidence-based rehabilitative service and practice using an integrated care model, and providing motivational interviewing, stage-wise interventions, cognitive-behavioral, harm reduction techniques, and linkage to community support groups, to restore functionality and promote recovery for individuals with dual recovery substance use disorder and mental illness.
k. Individual, Group, and/or Family Psychotherapy
l. Peer Support Services.
m. Family Peer Support Services.
n. Self-management and Skill Training. Rehabilitative skills training services to restore and maximize an individual's independence in personal health care and wellness by increasing the individual's awareness of the individual's physical and mental health status and the resources required to maintain physical health and effectively manage serious mental health conditions, including coping skills training, disability education, and relapse prevention training.
o. Psychosocial Rehabilitative Services. Rehabilitative service focusing on behavioral, social, communication, rehabilitation, and/or basic living skills training to increase a participant's functioning and decrease mental health and/or behavioral symptoms. This addresses an individual's ability to function adaptively in home and community settings. Examples of training areas that may be addressed include self-care, behavior, social decorum, avoidance of exploitation, anger management, budgeting, development of social support networks, and use of community resources.

Provider Qualifications:
ACT Services are provided by licensed professional staff, and by unlicensed staff under the supervision of licensed staff. The mobile, multidisciplinary team ACT team includes at least one of the following:
1) Licensed Clinical Professional Counselor (LCPC)
2) Licensed Clinical Social Worker (LCSW)
3) Licensed Marriage and Family Therapist (LMFT)
4) Licensed Masters Social Worker (LMSW)
5) Licensed Nurse Practitioner
6) Licensed Physician
7) Licensed Physician's Assistant
8) Licensed Practical Nurse
9) Licensed Professional Counselor (LPC)
10) Licensed Psychiatric Nurse
11) Licensed Psychiatric Nurse Practitioner
12) Licensed Psychiatrist
13) Licensed Psychologist
14) Licensed Registered Professional Nurse
15) Licensed Social Worker (LSW)
16) Any other behavioral health or substance use disorder license type recognized by the Idaho Division of Professional Licensing (DOPL)

Unlicensed staff must:
a) Be at least eighteen (18) years old.
b) Have attained a high-school diploma or equivalent.
c) Have at least six (6) months of documented direct care experience with individuals with Serious and Persistent Mental Illness (SPMI).
d) Completed State Medicaid Agency designated training.

Professional staff supervision for unlicensed staff occurs both formally, through direct supervision and clinical consultation availability, as well as informally, through regular organizational and service planning meetings, which are a hallmark of the ACT evidence-based practice model.

All ACT Services providers are required to have completed State Medicaid Agency identified training within ninety (90) calendar days of first rendering services.

Peer Support, including Youth Support - Provider Qualifications
1. Eighteen (18) years of age or older.
2. Obtained a high school diploma or GED.
3. Obtained State Medicaid Agency approved certification as a Peer Support Specialist or Recovery Coach.
4. Be supervised by a licensed behavioral health professional.
5. Completed a criminal history and background check or received a State Medicaid Agency waiver.
6. Completed State Medicaid Agency identified training.
7. For Youth, transitioned out of treatment at least one (1) year ago.
8. For Youth, completed endorsement as a Youth Support Specialist.

Family Support - Provider Qualifications
Family Support providers must receive training and certification as a Peer Support Specialist. Family Support providers must be supervised by an independently licensed clinician who has direct knowledge and contact with the families receiving the service.

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 prior authorization.

Audiologist services are covered for individuals with hearing disorders when provided by an audiologist who is licensed by the Speech and Hearing Services Board of the Idaho Board of Occupational Licenses.
~ Participants age twenty-one (21) and older are eligible to receive diagnostic audiology services necessary to obtain a differential diagnosis.
~ Participants under the age of twenty-one (21) are eligible to receive necessary audiometric services and supplies.
~ The State Medicaid Agency will prior authorize audiometric examination/testing if needed more

frequently than once per year.

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 State Medicaid Agency, but not covered by the Base Benchmark: Bariatric Surgery.

Other 1937 Benefit Provided:
Behavior Modification and Consultation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Limited to children under age eighteen (18) who have been diagnosed with Serious Emotional Disturbance (SED).

Other:
Behavior Modification and Consultation services emphasize the replacement of problematic or inappropriate behaviors with positive behaviors and increasing the ability of the participant to exhibit more effective and appropriate behaviors. Behavioral strategies are used to teach the participant alternative means to deal with targeted behaviors and the environment to ensure inappropriate behaviors are eliminated and positive behaviors are learned and maintained. Behavior modification providers may provide assistance to help develop or maintain prosocial behaviors at any time and in any setting appropriate to meet the participant's needs, including home, school, and community. In compliance with EPSDT, this service is covered for children through the month of their twenty-first (21st) birthday when medically necessary.

Behavior modification providers focus on social and behavioral skill development by building a participant's competencies and confidence. These services are individualized and are related to goals identified in the participant's treatment plan.

Behavior modification services typically include development, implementation and monitoring of a behavioral management plan and other rehabilitation services identified in the behavior management plan. Once the behavior management plan is implemented, behavioral strategies can alter or improve specific

behaviors when consistently applied by family members, teachers, and professional therapists working in concert with the participant until the behavior is effectively managed.

After assessment, the resulting behavioral management treatment plan can also include a risk-management or contingency plan developed to address the needs of the participant.

Provider Qualifications
Behavior modification and consultation providers must obtain a nationally recognized certification for providers of services related to behavior analysis and modification. Independently licensed clinicians or Master's-level clinicians and paraprofessionals who meet supervisory protocol may provide this service.

There are four (4) nationally recognized certifications for providers of services related to behavior analysis and modification:
• Registered Behavioral Technician (RBT)—RBTs must: Be eighteen (18) years old with HS diploma; be supervised by BCaBA, BCBA, or BCBA-D; pass competency assessment and RBT exam.
• Board Certified Assistant Behavior Analyst (BCaBA)—BCaBAs must: Be Bachelor's level; be supervised by a BCBA or BCBA-D; pass BCaBA exam.
• Board Certified Behavior Analyst (BCBA)—BCBAs must: Be Master's level; pass BCBA exam; complete supervisor training.
• Board Certified Behavioral Analyst-Doctoral (BCBA-D)—BCBA-Ds must: Hold a Ph.D.; pass BCBA exam; complete supervisor training.

Other 1937 Benefit Provided:
Behavioral Consultation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
Thirty-six (36) hours per student per year

Duration Limit:
None

Scope Limit:
This service is provided to students in an educational setting pursuant to a signed and dated recommendation or referral by a physician or allowed non-physician practitioner.

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.

Provider Qualifications
Qualifications for Behavioral Consultation providers are:
1) Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in

psychology, education, applied behavioral analysis, or in a related discipline with one thousand five hundred (1,500) 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:
2) An individual with an Exceptional Child Certificate as defined by State law.
3) An individual with an Early Childhood/Early Childhood Special Education Blended Certificate as defined by State law.
4) A Special Education Consulting Teacher as defined by State law.
5) An individual with a Pupil Personnel Certificate as defined by State law, excluding a registered nurse or audiologist.
6) An occupational therapist who is qualified and registered to practice in Idaho.
7) Therapeutic consultation professional who meets the requirements defined by the State Medicaid Agency.

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.

Participants are able to choose to receive Medicaid services from the pool of qualified Medicaid providers, which includes school-based and community providers.

Participants through the month of their twenty-first (21st) birthday, pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the State Medicaid Agency.

Other 1937 Benefit Provided:

Behavioral Intervention

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Children through the month of their twenty-first (21st) birthday. No prior authorization is required when provided to students in an educational setting pursuant to signed and dated recommendation/referral by a physician or other allowed practitioner

Other:

Behavioral Intervention techniques are used to produce positive meaningful changes in behavior that incorporate functional replacement and reinforcement-based strategies while also addressing any identified habilitative skill building needs. These services are provided to participants who exhibit interfering behaviors that impact the independence or abilities of the participant, such as impaired social skills and communication or destructive behaviors. Intervention services may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Evidence-based or evidence-informed practices are used to promote positive behaviors and learning while reducing interfering behaviors and developing behavioral self-regulation.

Services may include individual or group services. Group services must be provided by one (1) qualified

staff providing direct services for two (2) or three (3) individuals. As the number and needs of the participants increase, the participant ratio in the group must be adjusted from three (3) to two (2). Group services should only be delivered when the participant's goals relate to benefiting from group interaction.

Behavioral Intervention may include interdisciplinary training to assist with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is intended to be utilized for collaboration, with the participant present, during the provision of services between a bachelor's-level intervention provider or Master's-level intervention provider and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional or behavioral/mental health professional. A bachelor's-level may provide this service if they meet the supervisory protocol required.

Provider Qualifications
Providers who have obtained a nationally recognized certification for services related to applied behavior analysis. Independently licensed clinicians, Master's-level individuals, bachelor's-level individuals, and paraprofessionals who meet supervisory protocol may also provide this service.

Other 1937 Benefit Provided:

Care Planning through Child and Family Team (CFT)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

A planning team is responsible for successfully completing a person-centered planning process that will culminate in a person-centered service plan and other treatment plans, as needed, which will be used to inform and guide the ongoing treatment of the participant. Participation on this team, referred to as the Child and Family Team (or CFT), entails collaboration among diverse team members of the family's choosing; i.e., the CFT may include family members, a plan facilitator, the targeted care coordinator, treating clinicians and providers, the primary care physician, MH/SUDs professionals or paraprofessionals, and other persons selected by the family to be involved in the planning and/or delivery of the participant's care.

Planning activities take place within the framework of the CFT Interdisciplinary Team Meeting, which is an in-person or telephonic meeting, with the participant present, focused on developing, monitoring, or modifying a plan of care. In addition, CFT Interdisciplinary Team Meetings provide a forum in which the team can review the effectiveness of current services, assess the participant's progress towards objectives specified in the plans of care, and discuss treatment options and service adjustments for possible inclusion in revisions to planning documents.

The Care Planning benefit is the mechanism that will allow a Medicaid provider—when the provider will be actively involved in the development, implementation, and revision of the services prescribed in the plan(s)—to be reimbursed for attending planning sessions and participating on the CFT. In accordance with the core principles of person-centered planning, CFT Interdisciplinary Team Meetings are held at times and settings identified as convenient for the family.

The Care Planning benefit is limited exclusively to CFT participation. Periodic consultations between providers are considered a routine function of the practitioner, not a direct medical service to the participant, and therefore do not constitute a standalone service eligible for reimbursement.

Provider Qualifications
Medicaid-enrolled providers who are involved in the participant's care and have been selected by the family to serve on the CFT may bill for this service, including the provider types listed below:
1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Paraprofessionals who hold at least a Bachelor's degree and a current credential from the Psychiatric Rehabilitation Association (i.e., a certificate or certification in psychiatric rehabilitation based upon the primary population with whom the provider works, in accordance with the requirements set by the PRA), and who meet requirements of the Idaho State Medicaid Agency
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

Other 1937 Benefit Provided:
Children's Habilitation Crisis Intervention

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Children through the month of their twenty-first (21st) birthday

Other:
Crisis intervention services are provided face to face 24/7 in the community, school, or home of the participant in order to assess immediate strengths and needs to ensure appropriate services are provided to de-escalate the current crisis and prevent future crisis. Services to the participant's family and others who regularly participate in the participant's life are for the direct benefit of the participant, in accordance with the participant's needs and treatment goals identified in the participant's treatment plan, and for the purpose of assisting in the participant's recovery. This work includes the following activities: intervene, coordinate with current services, and provide linkages and referral for follow-up care to participants and families experiencing a psychological, behavioral or emotional crisis. Crisis interventions are intended to address the immediate safety and well-being of the participant and family due to the participant's escalating behaviors that may be creating disruption to the participant's functioning and stability. Crisis interventions are short-term and time-limited as identified by the participant, family, or crisis services provider.

Crisis intervention providers must be trained to deliver direct consultation and clinical evaluation of a child participant who is experiencing a crisis (i.e., being at risk of out-of-home placement, hospitalization, incarceration, physical harm to self or others, family altercations or other emergencies).

Provider Qualifications

Providers who have obtained a nationally recognized certification for services related to applied behavior analysis. Independently licensed clinicians, Master's-level individuals, bachelor's-level individuals, and paraprofessionals who meet supervisory protocol may also provide this service.

Remove

Other 1937 Benefit Provided:
Crisis Intervention

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Crisis intervention services are provided face to face 24/7 in the community or home of the participant in order to assess immediate strengths and needs to ensure appropriate services are provided to de-escalate the current crisis and prevent future crisis. Services to the participant's family and significant others are for the direct benefit of the participant, in accordance with the participant's needs and treatment goals identified in the participant's treatment plan, and for the purpose of assisting in the participant's recovery.

This work includes the following activities: intervene, coordinate with current services, and provide linkages and referral for follow-up care to participants and families experiencing a behavioral health crisis. Crisis interventions are intended to address the immediate safety and well-being of the participant and family due to the participant's escalating behaviors that may be creating disruption to the participant's functioning and stability. Crisis interventions are short-term and time-limited as identified by the participant, family, or crisis services provider.

Crisis intervention specialists will be required to have the capacity to assess, intervene, de-escalate, and produce a stabilization/crisis plan as well as follow up telephonically within twenty-four (24) hours with the participant/participant's family to assess participant stability and deliver crisis follow-up needs. The result of an outpatient Crisis Intervention is a stabilized participant who remains in the community, a stabilized child participant whose family elects to receive some unplanned respite, or a participant who gets linked with higher level of care or response.

Provider Qualifications
Any providers of this service will be required to obtain a State Medicaid Agency approved certification. Any unlicensed staff providing this service must be supervised by at least a Master's-level clinician.

The Master's-level clinician can be one (1) of the following:
- Licensed Professional Counselor (LPC)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Masters Social Worker (LMSW)
- Licensed Clinical Social Worker (LCSW)

Other 1937 Benefit Provided:
Crisis Response

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Crisis Response is delivered over the telephone, and the service is available 24/7 to help participants cope with a mental health crisis and remain in their own home and community. Crisis Response includes telephone contact with skilled crisis response providers who can furnish assessment and crisis de-escalation through counseling, support, active listening or other telephonic interventions, as well as offer linkage to services and community providers.

The goals of Crisis Response are to ensure the safety and emotional stability of the participant experiencing a mental health crisis, to avoid further deterioration in the participant's mental status, assist in the development or enhancement of more effective coping skills and support system, raise the participant's level of functioning, help in obtaining ongoing care by way of outreach to existing support services, community mental health, substance use and/or medical healthcare providers.

On occasion, the crisis response provider may determine that a higher level of intervention is indicated. Typical circumstances may involve a participant who is determined to be:
• Threatening imminent harm to self or others;
• Severely disoriented or out of touch with reality;
• Functionally or physically impaired;
• Extremely distraught and out of control; or
• Severely impaired by drugs or alcohol.

The presence of these risk factors suggest that the crisis has become a potentially life-threatening situation and a mental health emergency exists. In such cases, the crisis response provider will make contact with emergency responders who can evaluate whether a higher level of care is warranted.

Provider Qualifications
Crisis Response providers are:
1) Paraprofessionals who hold at least a Bachelor's degree in a human services field, are certified in their field (Crisis Response and Intervention from the Crisis Prevention Institute), and who meet requirements of the State Medicaid Agency; or
2) Master's level clinicians or higher level who are licensed to practice independently in Idaho.

Other 1937 Benefit Provided:
Dental Services: Adults

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.

Other services covered by the State Medicaid Agency, but not covered by the Base Benchmark: Adult Dental Services.

Adult individuals receive all medically necessary preventative and restorative dental services, including:
Preventive dental services:
- Oral exam every twelve (12) months
- Cleaning every six (6) months
- Fluoride treatment every twelve (12) months
- Dental X-rays every twelve (12) months (Full mouth or Panoramic every 36 months)

Restorative Dental Services:
- Medically necessary exams
- Fillings are covered once in a twenty-four (24) month period per tooth/surface
- Simple and surgical extractions
- Endodontic services include therapeutic pulpotomy and pulpa debridement
- Periodontic services include scaling and root planing, full mouth debridement
- Periodontal maintenance is covered up to two (2) visits every twelve (12) months

Dentures:
-Dentures are covered once every seven (7) years.
Limitations may be exceeded if medically necessary.

Exclusions:
Drugs supplied to dental patients for self-administration other than those allowed by applicable State Medicaid Agency rules.

Non-medically necessary cosmetic services.

Limitations:
The State Medicaid Agency may require prior approval for specific elective dental procedures.

Other 1937 Benefit Provided:
Dentures

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
One (1) set every seven (7) years

Duration Limit:
None

Scope Limit:

Dentures for the purpose of restoring oral form and function due to loss of permanent teeth that would result in significant occlusal dysfunction.

Other:

Dentures are covered for children through the month of their twenty-first (21st) birthday when medically necessary. Limitations may be exceeded if medically necessary.

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 State Medicaid Agency covers some items not covered by the Base Benchmark.
- The State Medicaid Agency will replace DME more frequently than five (5) years when determined to be medically necessary.

Other 1937 Benefit Provided:

Early Intervention Services (EIS)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Available to Medicaid-eligible children who meet Individuals with Disabilities Education Act (IDEA) Part C requirements pursuant to a signed and dated physician referral or recommendation.

Other:

Early Intervention Services (EIS) are Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) services provided to Idaho Medicaid participants through the IDEA Part C Lead Agency. The IDEA Part C Lead Agency is responsible for assessing and treating the developmental needs of infants and toddlers and the needs of the family related to enhancing the child's development. Services to the participant's family and significant others are for the direct benefit of the participant, in accordance with the participant's needs and treatment goals identified in the participant's treatment plan, and for the purpose of assisting in the participant's recovery.

An EIS provider is responsible for:
a. Responding to referrals for assessing and screening Medicaid eligible infants and toddlers for EIS.
b. Educating families on options for services through the IDEA Part C Lead Agency and providing referrals to other EPSDT providers or community resources.
c. Participating in the multidisciplinary team's ongoing assessment of the participant and family's resources, priorities, and concerns as related to the needs of the infant or toddler, in the development of integrated goals and outcomes for the Individualized Family Service Plan (IFSP).
d. Providing EIS in accordance with the IFSP.
e. Consulting with and training parents and others regarding the provision of the EIS described in the participant's IFSP.

EIS are delivered as part of the statewide comprehensive, coordinated, multidisciplinary interagency system for EIS. The following age-appropriate screenings, evaluations and services are covered when delivered by an early intervention provider:
a. Developmental, motor, language, social, adaptive, and cognitive functioning testing and interpretation.
b. Development, review, and implementation of IFSPs.
c. EIS including therapy services, family training, home care training, and interdisciplinary teaming.

Provider Qualifications:
EIS for infants and toddlers enrolled in Idaho Medicaid are provided by the IDEA Part C Lead Agency (Idaho Infant Toddler Program, or ITP). The ITP must hold a valid Idaho Medicaid EIS provider agreement and comply with all provider screening requirements as specified in Idaho administrative code IDAPA 16.03.09 Medicaid Basic Plan Benefits.

All personnel providing EIS must be employed by or contracted with Idaho ITP, meet the IDEA Part C requirements, and meet all Medicaid regulations. Idaho Code, Title 16, Chapter 1 requires the Idaho ITP to ensure that individuals providing EIS meet Idaho's established certification or licensing standards within the scope of their practice and that they are appropriately and adequately trained. ITP personnel providing EIS include the following professions or disciplines providing the services designated:

a. Audiologist – Hearing screenings and evaluations
b. Developmental Specialist – Assessment and services
c. Family Therapist – Social/emotional assessment and services
d. Marriage and Family Therapist – Social/emotional assessment and services
e. Professional Counselor – Social/emotional assessment and services
f. Occupational Therapist – Occupational therapy assessment and services
g. Orientation/Mobility Specialist – Assessment and services for vision impaired
h. Optometrist – Vision assessment
i. Pediatrician/Physician – Plan development and oversight
j. Physician Assistant – Plan development and oversight
k. Nurse Practitioner – Plan development and oversight
l. Physical Therapist (PT) – Physical therapy assessment and services
m. Psychologist – Assessments/behavioral health services
n. Registered Dietitian –Dietary counseling services
o. Registered Nurse – Nursing services
p. Licensed Practical Nurse – Nursing services
q. Social Worker –Service Coordination/Social work services
r. Clinical Social Worker –Service Coordination/Social work services
s. Master's-level Social Worker –Service Coordination/Social work services
t. Speech-Language Pathologist – Speech-language assessments and therapy services
u. Teacher for Visually Impaired – Communication skills

Other 1937 Benefit Provided:
Family Psychoeducation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Family Psychoeducation (FPE) is an approach for partnering with participants and families to treat participants with behavioral health diagnoses. In contrast with family therapy, Family Psychoeducation emphasizes the behavioral health condition as the focus of instruction, not the family. While psychoeducation is a typical component of psychotherapy, it is also an effective service when provided as a targeted service to a single family or group of families. Services to the participant's family and significant others are for the direct benefit of the participant, in accordance with the participant's needs and treatment goals identified in the participant's treatment plan, and for the purpose of assisting in the participant's recovery.

Rather than a short-term intervention, Family Psychoeducation is a series of meetings that present a pre-established curriculum comprising counseling to families based on the participant's specific medical needs.

Family Psychoeducation can be provided in a multifamily group (two (2) to five (5) families) or in a single-family format. Services provided should be identified on the participant's plan of care, and driven by the participant's and family's goals.

Family Psychoeducation supports the participant/family/caregivers in understanding aspects such as:
• The participant's symptoms of the behavioral health condition and nature of their specific illness
• The impact symptoms have on the participant's development and functioning across environments
• The components of treatment that are known to be effective for the participant's specific condition
• The concept of rehabilitation through skill development
• Other important elements of treatment (e.g., Medication and Medication Compliance)

Provider Qualifications
Single-family psychoeducation requires a master's-level, independently licensed clinician (Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Clinical Professional Counselor) or a master's-level provider qualified to deliver psychotherapy in a group agency under supervision. In cases where providers are working with a single family having many participants or complex issues, the family could benefit from the involvement of a second facilitator. Multifamily psychoeducation warrants two (2) facilitators; at least one (1) of these will be an independently licensed clinician or or a master's-level provider qualified to deliver psychotherapy in a group agency under supervision. The second facilitator may be a bachelor's-level paraprofessional operating in a group agency under supervision.

Other 1937 Benefit Provided:
Family Support

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Age twenty-one (21) and under with a diagnosis of Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI).

Other:
Family Support services are provided to parents or primary caregivers of a youth with SED or SMI by another parent or primary caregiver (certified as a Peer Support Specialist) with a lived experience raising a youth with SED or SMI. The Family Support Specialist will assist and support the family or primary caregiver in gaining access to services, and help the family or primary caregiver become informed consumers of services and self-advocates. Family support may include mentoring, advocating, and educating, provided one-on-one to the family or primary caregiver or through family support groups. The Family Support Specialist provides support, information, and resources to families to accomplish the treatment goals being targeted for the youth, and may also work in partnership with the youth's therapist and treatment team to bridge the relationship between the parent or primary caregiver and professionals working with the youth. Services to the youth's family and significant others are for the direct benefit of the youth, in accordance with the needs and treatment goals identified in the treatment plan, and for the purpose of assisting in the youth's recovery.

Family Support providers must receive training and certification as a Peer Support Specialist. Family Support providers must be supervised by an independent licensed behavior health professional who has direct knowledge and contact with the families receiving the service.

Other 1937 Benefit Provided:
Habilitative Skill Building

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Children through the month of their twenty-first (21st) birthday
No prior authorization is required when provided to students in an educational setting pursuant to signed and dated recommendation/referral by a physician or other allowed practitioner.

Other:
Habilitative skill building includes techniques used to develop, improve and maintain, to the maximum extent possible, the developmentally-appropriate functional abilities and daily living skills of an individual. These services may include teaching or coordinating methods of training with family members or others who regularly participate in caring for the eligible participant.

Services may include individual or group interventions. Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) participants. As the number and needs of the

participants increase, the participant ratio in the group must be adjusted from three (3) to two (2). Group services should only be delivered when the participant's goals relate to benefiting from group interaction. Habilitative skill building may include interdisciplinary training to assist with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is intended to be utilized for collaboration, with the participant present, during the provision of services between a bachelor's-level intervention provider or Master's-level intervention provider and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional or behavioral/mental health professional. A bachelor's-level may provide this service if they meet the supervisory protocol required.

Provider Qualifications
Providers who have obtained a nationally recognized certification for services related to applied behavior analysis. Independently licensed clinicians, Master's-level individuals, bachelor's-level individuals, and paraprofessionals who meet supervisory protocol may also provide this service.

Remove

Other 1937 Benefit Provided:
Home Health Care Services

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 hundred (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 twenty (20) visits per year combined for outpatient PT/OT/SLP services.

The State Medicaid Agency will cover up to one hundred (100) visits without PA for any combination of Home Health Aide, Physical Therapy, Occupational Therapy, or Speech-Language Pathology services. More can be authorized when medically necessary. This benefit does not include Skilled Nursing services.

Remove

Other 1937 Benefit Provided:
ICF/ID

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Program Description: Services in an intermediate care facility for the intellectually disabled; § 1905(a)(15) of the Act.

The State Medicaid Agency will comply with all requirements at 42 C.F.R. § 440.150.

Other services covered by the State Medicaid Agency, but not covered by the Base Benchmark: ICF/ID – Intermediate Care Facility for the Intellectually Disabled.

Other 1937 Benefit Provided: IMD for Adults age 65 and over

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 participants age sixty-five (65) and over in an Institution for Mental Diseases.

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 State Medicaid Agency, but not covered by the Base Benchmark: Inpatient hospital services for individuals age sixty-five (65) or over in Institutions for Mental Diseases.

The State Medicaid Agency assures that requirements of 42 C.F.R. Part 441, Subpart C, and 42 C.F.R. § 431.620(c) and (d) are met.

The State Medicaid Agency provides assurance that providers of inpatient psychiatric services for individuals under twenty-one (21) shall meet the requirements of 42 C.F.R. § 440.160(b) and Subpart D of 42 C.F.R. 441 regarding certification and accreditation requirements.

The State Medicaid Agency provides assurance that inpatient psychiatric services for individuals under twenty-one (21) comply with restraint and seclusion requirements at 42 C.F.R. 483 Subpart G.

Other 1937 Benefit Provided: Individual and Family Medical Social Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Other

Amount Limit: Two (2) visits

Duration Limit: Pregnancy and six (6) weeks postpartum

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 State Medicaid Agency, but not covered by the Base Benchmark: Services directed at helping a participant to overcome social or behavioral problems which may adversely affect the outcome of pregnancy and childbirth.

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:

Inpatient Psychiatric Services Under Age 21

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Other

Other:

Services are provided in accordance with:
42 CFR § 440.160 Inpatient psychiatric services for individuals under age 21
42 C.F.R. Part 441 Subpart D—Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs
42 C.F.R. Part 483 Subpart G Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

Services must be provided under the direction of a physician.

Services can be provided by:
(a) A psychiatric hospital that undergoes a State Medicaid Agency survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by the Centers for Medicare and Medicaid Services (CMS).
(b) A hospital with an inpatient psychiatric program that undergoes a State Medicaid Agency survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.
(c) A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State Medicaid Agency. The facility must also be licensed

in the host state, and must be certified by CMS as a Psychiatric Residential Treatment Facility.

Inpatient psychiatric services furnished in a psychiatric residential treatment facility must satisfy all state and federal requirements governing the use of restraint and seclusion.

Scope Limit:
Provided before the individual reaches age twenty-one (21), or, if the individual was receiving the services immediately before they reached age twenty-one (21), before the earlier of the following: (i) The date the individual no longer requires the services; or (ii) The date the individual reaches twenty-two (22).

42 C.F.R. § 441.152 Certification of need for services.
(1) Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary.
(2) Proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician.
(3) The services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that the services will no longer be needed.
(4) The certificate satisfies the utilization control requirement for physician certification.

42 C.F.R. § 441.154 Active treatment.
Inpatient psychiatric services must involve "active treatment", which means implementation of a professionally developed and supervised individual plan of care, that is—
(a) Developed and implemented no later than 14 days after admission; and
(b) Designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time.

42 C.F.R. § 441.155 Individual plan of care.
An individual written plan of care must be developed to improve the individual's condition to the extent that inpatient care is no longer necessary. The plan must be reviewed, and revised if applicable, every thirty (30) calendar days and include, at an appropriate time, post discharge plans and coordination of services.

Provider Qualifications
An interdisciplinary team must develop and deliver the plan of care. The team must include, at a minimum, either—
(a) A Board-eligible or Board-certified psychiatrist;
(b) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
(c) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state.

The team must also include a master's level social worker or counselor, and one of the following:
(1) A registered nurse with specialized training or one (1) year of experience in treating mentally ill individuals.
(2) An occupational therapist who is licensed and who has specialized training or one (1) year of experience in treating mentally ill individuals.
(3) A psychologist who has a master's degree in clinical psychology or who has been certified by the state.

Other 1937 Benefit Provided:	Source:	
Licensed Midwife	Section 1937 Coverage Option Benchmark Benefit Package	Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

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

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

Other services covered by the State Medicaid Agency, 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:
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 State Medicaid Agency, 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 "Other 1937 Benefits" as Nursing Facility: Rehabilitative and Nursing Facility: Custodial Care, along with the Skilled Nursing Facility benefit in the EHB 7 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 State Medicaid Agency requires that the nursing facility services include at least the items and services specified in 42 C.F.R. § 483, including 42 C.F.R. § 483.10(c)(8)(i).

Other 1937 Benefit Provided:
Nursing Facility: Rehabilitative

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
Thirty (30) days per year

Duration Limit:
None

Scope Limit:
Skilled Nursing Facility services for rehabilitation.

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 thirty (30) days per year for only certain conditions. The State Medicaid Agency will cover rehabilitative skilled nursing facility services in excess of the thirty (30) days per year covered by the Base Benchmark if the participant is showing progress toward rehabilitation goals.

The nursing facility benefits defined in "Other 1937 Benefits" as Nursing Facility: Rehabilitative and Nursing Facility: Custodial Care, along with the Skilled Nursing Facility benefit in the EHB 7 section of this template, reflect the state's approved nursing facility benefit in the state plan.

The State Medicaid Agency requires that the nursing facility services include at least the items and services specified in 42 C.F.R. § 483 including 42 C.F.R. § 483.10(c)(8)(i).

Other 1937 Benefit Provided:
Optometrist and Ophthalmologist Services: Adults

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:
One pair glasses or contacts post cataract surgery

Duration Limit:
None

Scope Limit:
None

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 State Medicaid Agency, but not covered by the Base Benchmark:
Optometrist and Ophthalmologist Services for adults.

The State Medicaid Agency 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. One (1) pair of glasses or contacts is covered post cataract surgery.

Other 1937 Benefit Provided:
Outpatient Habilitation: OT, PT, 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 State Medicaid Agency covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark aggregate twenty (20) visit limit. Claims exceeding current Medicare dollar caps are subject to targeted review for medical necessity.

Other 1937 Benefit Provided:
Outpatient Rehabilitation Services: PT, OT, SLP

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 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 current Medicare dollar caps are subject to targeted review for medical necessity.

Other 1937 Benefit Provided:
Parenting With Love And Limits (PLL) (Rehab)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
Six (6) months in a twelve (12) month period.

Scope Limit:
Other

Other:

Program Description
Parenting with Love and Limits (PLL) is a family-focused evidenced-based intervention for children with a Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD) diagnosis. The benefit is designed to help families re-establish adult authority through setting consistent limits and reclaiming loving relationships.

PLL consists of both multi-family group therapy sessions and individual family therapy coaching sessions.

Multifamily group therapy sessions are led by two (2) facilitators, including one (1) clinician and one co-facilitator. Group session topics include reasons for a child's behavior, behavior contracts, positive feedback, and approaches for restoring nurturing relationships.

Individual family therapy coaching sessions are intended to complement the group sessions and follow four (4) phases of treatment. The first phase sets the terms of the therapy. The second and third phases focus on developing a behavioral contract and role-playing skills learned in group sessions. The fourth and final phase focuses on evaluating and maintaining progress and preventing relapse. After initial work to stabilize the family system, clinicians also address trauma in the family system, as needed.

Scope Limit:
Services are considered to be delivered on behalf of, and for the benefit of, the child. Individuals through the month of their twenty-first (21st) birthday, pursuant to EPSDT, may receive services if determined to be medically necessary and prior authorized by the State Medicaid Agency.

Provider Qualifications
Multifamily group therapy sessions are led by two (2) facilitators consisting of one (1) clinician and one co-facilitator. The individual family therapy sessions are led by a clinician. Clinicians must have at least a master's degree in a counseling related field, hold applicable state licensure, and complete State Medicaid Agency designated training. Co-facilitators must have at least a bachelor's degree and complete State Medicaid Agency designated training.

Other 1937 Benefit Provided:
Peer Support, including Youth Support

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Peer Support includes Adult Peer Support, Youth Support, and Recovery Coaching.

These are face-to-face recovery support services in which an appropriately certified Peer, who is actively engaged in their own recovery process, mentors, guides, and coaches the participant to achieve self-identified recovery and resiliency goals. The Peer helps link participants to services and supports and to the recovery community.

Adult peer support specialists provide peer support to participants with a serious mental illness (SMI), youth peer support specialists serve youth with serious emotional disturbance (SED), and recovery coaches work with adults with substance use disorder (SUD). This specialized support is intended to complement an array of therapeutic services and may be offered before, during, or after behavioral health treatment to facilitate long-term recovery in the community.

Components of the Peer Support service may include:
- Creating an individualized recovery plan that reflects the participant's needs, preferences, and goals;
- Encouraging self-determination, hope, insight, and the development of new skills;
- Empowering participants to engage in their own treatment, healthcare and recovery;
- Connecting the participant with professional and non-professional recovery resources in the community and helping the participant navigate the service system;
- Helping the participant decrease isolation and build a community supportive of the participant establishing and maintaining recovery.
- Facilitating peer support groups of four (4) or more participants.

Provider Qualifications
1. Eighteen (18) years of age or older.
2. Obtained a high school diploma or GED.
3. Obtained State Medicaid Agency approved certification as a Peer Support Specialist or Recovery Coach.
4. Be supervised by a licensed behavioral health professional.
5. Completed a criminal history and background check or received a State Medicaid Agency waiver.
6. Completed State Medicaid Agency identified training.
7. For Youth, transitioned out of treatment at least one (1) year ago.
8. For Youth, completed endorsement as a Youth Support Specialist.

Other 1937 Benefit Provided: Personal Care Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

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. Children may also receive PCS as a school-based service.

Other:

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

Other services covered by the State Medicaid Agency, 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 a State Medicaid Agency 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 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 the intellectually disabled, or institution for mental diseases.

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

The PCS described above are furnished in the participant's place of residence, which may include:
• Personal Residence.
• Certified Family Home. A home certified by the State Medicaid Agency 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 State Medicaid Agency 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.

PCS can also be provided to a student as a school-based service. To be eligible, a student must have a completed children's PCS assessment and allocation tool approved by the State Medicaid Agency. The assessment results must find that the student requires PCS due to a medical condition that impairs the physical or functional abilities of the student. The provider of school-based PCS must deliver at least one (1) of the following services:
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 student to and from the bathroom or assisting the student with bathroom routines;
c. Assistance with food, nutrition, and diet activities, including preparation of meals if incidental to medical need;
d. Assisting the student with physician-ordered medications that are ordinarily self-administered;
e. Non-nasogastric gastrostomy tube feedings, if the task is not complex and can be safely performed in the given student care situation.

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), a person listed on the CNA Registry who performs selected nursing services under the supervision of a registered professional nurse 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, who must be at least eighteen (18) years of age and receive training to ensure the quality of services. Services may be provided by any 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 (§ 1902(a) (23) of the Act). Eligible participants (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 adherence to Health Insurance Portability and Accountability Act (HIPAA) and agency confidentiality guidelines.
• Universal precautions - Knowledge of how infection is spread, proper handwashing techniques, and currently accepted practice of infection control; knowledge of currently accepted practice for handling and disposition of bodily fluids.
• Documentation - Knowledge of basic guidelines and fundamentals of documentation.
• Reporting - Knowledge of mandatory and incident reporting, as well as one's role in reporting condition changes.
• Care plan implementation - Knowledge of utilization of care plan when delivering participant services.

Based on the participant's State Medicaid Agency 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 C.F.R. § 483.430(a).

Individuals through the month of their twenty-first (21st) birthday, pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the State Medicaid Agency.

Remove

Other 1937 Benefit Provided: Podiatrist Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

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.

Routine foot care is not covered.

Other:

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

Other services covered by the State Medicaid Agency, but not covered by the Base Benchmark: Podiatrist Services.

Remove

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:

Idaho Medicaid provides coverage to Medicaid participants for the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under § 1927(d)(2) of the Social Security Act:

| | (A) Agents when used for anorexia, weight loss, or weight gain.

| | (B) Agents when used to promote fertility.

| | (C) Agents when used for cosmetic purposes or hair growth.

| | | (D) Agents when used for the symptomatic relief of cough and colds.
| X | (E) Agents when used to promote smoking cessation.
| X | (F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
Covered agents include: Injectable vitamin B12 (cyanocobalamin and analogues); vitamin K and analogues; prescription vitamin D and analogues; prescription pediatric vitamin-fluoride preparations; prescription pediatric vitamins, minerals, and flouride preparations; prenatal vitamins for pregnant or lactating individuals; prescription vitamin D and analogues; prescription folic acid; and oral prescription drugs containing folic acid in combination with vitamin B12 and/or iron salts, without additional ingredients.
| X | (G) Nonprescription drugs, except, in the case of pregnant women when recommended in accordance with Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposed of promoting, and when used to promote, tobacco cessation.
Certain prescribed non-prescription products are covered, including: Permethrin; oral iron salts; disposable insulin syringes and needles; insulin; and tobacco cessation products.
| | (H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
| X | (I) Barbiturates
| X | (J) Benzodiazepines
| | (K) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

Additional Excluded Drugs
Drugs are also not covered when the following circumstances apply:
• The participant's practitioner has written an order for a prescription drug for which federal financial participation is not available.
• The participant's practitioner has written an order for a prescription drug that is deemed to be experimental or investigational, as defined in Idaho administrative code IDAPA 16.03.09. Medicaid Basic Plan Benefits. Investigational drugs are not a covered service under the Idaho Medicaid pharmacy program. The State Medicaid Agency may consider Medicaid coverage on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available.
• The participant's practitioner has written an order for a covered outpatient drug for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
• The Idaho Medicaid Pharmacy Program receives a provider reimbursement claim for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment.
• The participant is dually eligible for Medicare and Medicaid, and the prescribed drug or drug class is covered under Medicare Part D. In the case of dual eligibles, the State Medicaid Agency will pay for only those Medicaid-covered drugs not covered under Medicare Part D.

Covered Outpatient Drugs
Medical necessity is the primary determinant of whether a therapeutic agent will be covered. The State Medicaid Agency will cover generic drugs, and also brand drugs when medically necessary and that necessity is adequately documented. If case-specific indications of medical necessity are present, the State Medicaid Agency may also issue prior authorization for otherwise excluded drugs.

Idaho Medicaid maintains a Preferred Drug List (PDL) that identifies the preferred drugs and non-preferred drugs within a therapeutic class. The Director of the State Medicaid Agency makes final decisions regarding drugs' designated preferred or non-preferred status based on therapeutic recommendations from the Pharmacy and Therapeutics Committee and cost analysis from the Idaho Medicaid Pharmacy Program A brand name drug may be designated as a preferred drug by the State Medicaid Agency if, after consideration of all rebates, the net cost of the brand name drug is less than the cost of the generic

equivalent.

The Director of the State Medicaid Agency, acting upon the recommendation of the Pharmacy and Therapeutics Committee, may determine that a non-prescription drug product is covered when the non-prescription product is found to be therapeutically interchangeable with prescription drugs in the same pharmacological class following evidence-based comparisons of efficacy, effectiveness, clinical outcomes, and safety, and the product is deemed by the State Medicaid Agency to be a cost-effective alternative.

Remove

Other 1937 Benefit Provided:
Preventive 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 EHB 9 and is being approved as Secretary-Approved Coverage.

Other services covered by the State Medicaid Agency, but not covered by the Base Benchmark: Preventive Health Assistance.

Coverage includes certain Preventive Health Assistance (PHA) benefits for individuals in the target group, provided in accordance with applicable State Medicaid Agency rules.

PHA benefits are individualized benefits to address target health behaviors. Authorizations will be managed by the State Medicaid agency. PHA benefits made available under this plan will target 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 materials 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:
Private-Duty Nursing

Source:
Section 1937 Coverage Option Benchmark Benefit Package

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 State Medicaid Agency, 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 skilled nursing services. All PDN services are ordered by a physician and provided under a written plan of care.

Limitations. The following service limitations apply to the Enhanced Alternative Benefit Plan covered under the State plan.
• PDN services must be authorized by the State Medicaid Agency 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 the child 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 schools.

Other 1937 Benefit Provided:

Residential Treatment, Behavioral Health

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

Other

Duration Limit:

Other

Scope Limit:

Other

Other:

A behavioral health residential treatment facility is a non-hospital facility that provides comprehensive, multi-faceted treatment in a residential setting to participants who have multiple significant behavioral health symptoms and needs that impair their ability to safely function in the home, school, or community setting.

The treatment facility provides therapeutic services that are appropriate for participants whose psychiatric, behavioral, or cognitive problems are so severe that residential care is required.

Services are provided under the direction of a physician, non-physician practitioner, or master's-level licensed clinical behavioral health professional in a separate, stand-alone entity.

Participants must meet medical necessity criteria for the level of care throughout their admission.

Participants must have a comprehensive assessment to determine eligibility. Assessments must be conducted by appropriately licensed clinical professionals trained in clinical assessments and operating within the scope of their licensure. The assessment should include information to substantiate the participant's diagnosis with sufficient details to allow for an individualized plan of care with personal goals and objectives.

Placement into a residential treatment facility is based on documented needs and the inability of less restrictive settings to meet those needs.

Plan of Care
Behavioral health residential treatment facility services require an individualized plan of care. The plan of care must be developed with the participant and their legal guardian, if applicable, unless otherwise clinically indicated by an appropriately licensed clinical professional.

The plan of care must be reviewed by a licensed clinical professional at regular intervals. Reviews must include if services are still necessary, and recommended adjustments based on the participant's condition.

Covered Services and Limitations
Services must be based on a comprehensive assessment and an individualized plan of care.

Reimbursement for residential treatment does not include room and board services, including custodial care. Reimbursement for residential treatment does not include vocational, education, or recreational costs.

Services are not provided in an IMD, unless under an approved 1115 demonstration authority.

Available covered services and interventions must include the following, at a minimum:
- Behaviorally focused skill building.
- Case consultation.
- Crisis intervention (available twenty-four (24) hours).
- Diagnostic assessments.
- Focused therapeutic interventions.
- Psychoeducation.
- Psychotherapy (Individual, Family, Group, Multiple-Family Group).
- Service coordination or clinical case management.
- Social and interpersonal skills.
- Treatment planning.

Policies and procedures must include medical screening and care for conditions requiring minor treatment and first aid as well as medical emergencies. A written provision for referral or transfer to a medical facility

must be present when additional medical care is warranted.

Discharge Planning and Criteria
The plan of care must identify criteria for discharge. These can include the following.
- Treatment goals have been met.
- A lower level of care can be reasonably expected to meet the participant's current needs.
- The participant and/or the family/guardians/primary caregivers withdraw the participant from treatment.
- The participant has remained stable for a reasonable period of time and/or seems to have reached the maximum therapeutic benefit.
- Continued stay guidelines are no longer met.

Leave of Absence
A leave of absence is covered when it is part of the plan of care. If the participant is hospitalized, the leave of absence is covered. A temporary absence is defined as no more than seventy-two (72) hours.

Provider Qualifications
Behavioral health residential treatment facilities must meet the following requirements.
- Have a National Provider Identification (NPI) number.
- Meet State Medicaid Agency identified certification.
- Meet all licensing and certification requirements for the states they are located.
- Enroll with the State Medicaid Agency prior to providing services and submitting claims for services.

Listed covered services and interventions are provided by licensed professional staff within their scope of practice, and by unlicensed staff under the supervision of licensed staff. The residential treatment team includes at least one of the following:
1) Licensed Clinical Professional Counselor (LCPC)
2) Licensed Clinical Social Worker (LCSW)
3) Licensed Marriage and Family Therapist (LMFT)
4) Licensed Masters Social Worker (LMSW)
5) Licensed Nurse Practitioner
6) Licensed Physician
7) Licensed Physician's Assistant
8) Licensed Practical Nurse
9) Licensed Professional Counselor (LPC)
10) Licensed Psychiatric Nurse
11) Licensed Psychiatric Nurse Practitioner
12) Licensed Psychiatrist
13) Licensed Psychologist
14) Licensed Registered Professional Nurse
15) Licensed Social Worker (LSW)
16) Any other behavioral health or substance use disorder license type recognized by the Idaho Division of Professional Licensing (DOPL)

Medication administration, and any medication changes, require a Licensed Nurse Practitioner or higher level of licensure.

Other 1937 Benefit Provided:	Source:	
Residential Treatment, Substance Use Disorder	Section 1937 Coverage Option Benchmark Benefit Package	Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

Other

Duration Limit:

Other

Scope Limit:

Other

Other:

A Substance Use Disorder (SUD) Residential Facility (SUDRF) is a non-hospital facility that provides residential substance use disorder and psychiatric services.

Services are provided under the direction of a physician in a separate, stand-alone entity.

Participants must meet medical necessity criteria for the level of care throughout their admission, in accordance with the most current edition of the American Society of Addiction Medicine (ASAM) Criteria.

Participants must have a comprehensive assessment to determine eligibility. Assessments must be conducted by appropriately licensed clinical professional trained in clinical assessments and operating within the scope of their licensure. The assessment should include information to substantiate the participant's diagnosis with sufficient details to allow for an individualized plan of care with personal goals and objectives.

Placement into a residential treatment facility is based on documented needs and the inability of less restrictive settings to meet those needs.

Plan of Care
Substance use disorder residential facility (SUDRF) services require an individualized plan of care. The plan of care must be developed with the participant and their legal guardian, if applicable, unless otherwise clinically indicated by an appropriately licensed clinical professional.

The plan of care must be reviewed by a licensed clinical professional at regular intervals. Reviews must include if services are still necessary, and recommended adjustments based on the participant's condition.

Covered Services and Limitations
Idaho Medicaid covers American Society of Addiction Medicine (ASAM) level 3.5 and 3.7 programs, as defined in the Fourth Edition of The ASAM Criteria, in a substance use disorder residential facility (SUDRF) when medically necessary for eligible participants.

Policies and procedures for both 3.5 and 3.7 facilities must include medical screening and care for conditions requiring minor treatment and first aid as well as medical emergencies. A written provision for referral or transfer to a medical facility must be present when additional medical care is warranted.

ASAM Level 3.5 admissions require a prior authorization.

Reimbursement for residential treatment does not include room and board services, including custodial care. Reimbursement for residential treatment does not include vocational or education costs.

Services are not provided in an IMD, unless under an approved 1115 demonstration authority.

Covered services include, at minimum, psychiatric services, psychological services, psychotherapies (individual, group), nursing services, and psycho-educational services. Services must be based on a

comprehensive assessment and an individualized plan of care.

ASAM Level 3.5
American Society of Addiction Medicine (ASAM) level 3.5 services (clinically managed high-intensity residential treatment) are intended for participants who are medically stable but cannot safely participate in addiction treatment without continuous twenty-four (24) hour supervision by behavioral health professionals. Participants admitted to level 3.5 facilities must meet ASAM criteria for a level 3.5 program throughout their admission.

Level 3.7 facilities must additionally provide active intoxication and withdrawal management (including all medications and laboratory tests) and be able to care for most chronic conditions, including exacerbations, in the context of withdrawal and withdrawal management.

ASAM Level 3.7
ASAM level 3.7 (medically managed residential treatment) services are intended for participants who need a high level of addiction treatment in a facility with twenty-four (24) hour nursing services and up to daily physician evaluation. Participants admitted to level 3.7 facilities have a severe SUD and need active medication management and nursing care to safely stabilize, typically during the withdrawal period, because of withdrawal symptoms or risks or unstable medical or psychiatric co-morbidities. Participants admitted to level 3.7 facilities must meet ASAM criteria for a level 3.7 program throughout their admission.

Provider Qualifications
SUDRF facilities must meet the following requirements.
● Have a National Provider Identification (NPI) number.
● Meet all licensing and certification requirements for the states in which they are located.
● Enroll with the State Medicaid Agency prior to providing services and submitting claims for services.
●Have current ASAM 3.5 and/or 3.7 Level of Care Certification from Commission on Accreditation of Rehabilitation Facilities (CARF) for the level(s) the facility intends to deliver.
● Have current national accreditation to provide behavioral healthcare by one of the following bodies:
-The Commission on Accreditation of Rehabilitation Facilities (CARF),
-The Joint Commission (TJC), or
-The Council on Accreditation (COA)

Listed covered services and interventions are provided by licensed professional staff within their scope of practice, and by unlicensed staff under the supervision of licensed staff. The residential treatment team includes at least one of the following:
1) Licensed Clinical Professional Counselor (LCPC)
2) Licensed Clinical Social Worker (LCSW)
3) Licensed Marriage and Family Therapist (LMFT)
4) Licensed Masters Social Worker (LMSW)
5) Licensed Nurse Practitioner
6) Licensed Physician
7) Licensed Physician's Assistant
8) Licensed Practical Nurse
9) Licensed Professional Counselor (LPC)
10) Licensed Psychiatric Nurse
11) Licensed Psychiatric Nurse Practitioner
12) Licensed Psychiatrist
13) Licensed Psychologist
14) Licensed Registered Professional Nurse
15) Licensed Social Worker (LSW)
16) Any other behavioral health or substance use disorder license type recognized by the Idaho Division of

Professional Licensing (DOPL)

Other 1937 Benefit Provided:
Respite

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
See other information section below for additional

Duration Limit:
See other information section below for additional

Scope Limit:
See other information section below for additional details.

Other:

Service Description:
Respite care is in-person short-term or temporary care for a youth with a diagnosis of Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) provided in the least restrictive environment that provides relief for the usual caretaker and is aimed at de-escalation of stressful situations. Short-term or temporary means three hundred (300) total hours or less in a twelve (12) month calendar period. Respite may be provided in the participant's home, another private residence, the credentialed agency, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers. Respite may only be provided when the care and supervision needs of the participant exceed those of a person of the same age without disabilities.

Target Group:
Children, under eighteen (18) years, who are determined to have serious emotional disturbance (SED) in accordance with Idaho Code § 16-2403 and have a Diagnostic and Statistical Manual of Mental Disorders (DSM, per the most current edition) mental health, emotional or behavioral disorder, or a neuropsychiatric condition diagnosable by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law.

Needs-Based Criteria:
Participants eligible to receive respite have a need for assistance due to substantial functional impairment (as documented in the CANS).

Substantial Functional Impairment:
The Child and Adolescent Needs and Strengths (CANS) assessment tool is used to measure substantial functional impairment. A rating from 0 to 3 is used on each item (where 0 = no evidence of a need, 1 = monitoring for need, 2 = need requiring intervention, and 3 = need requiring immediate or intensive intervention). The following three domains are central to a determination of substantial functional impairment associated with a treatable mental health condition:
1. Behavioral and Emotional Needs (this subscale contains 12 items on which the participant is rated);
2. Life Functioning (8 items);
3. Risk Behaviors (14 items).

The participant is considered to have substantial functional impairment when they have at least one item rated "2" or higher under the Behavioral and Emotional needs domain. In addition, under the Life Functioning domain - at least one item is rated a "2" or higher; OR
under the Risk Behaviors domain - at least one item rated at least a "2" (indicating a risk of danger to self or others associated with the psychiatric syndrome).

Institutional Level of Care:
The state assures that there are needs-based criteria for receipt of services in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and/or long-term care hospitals, and Medicaid waivers offering HCBS to individuals who meet institutional level of care, that are more stringent than the minimum needs-based criteria required to receive respite.

Home and Community-Based Service (HCBS) Settings:
Respite will be provided in settings that meet all HCBS settings requirements under 42 CFR § 441.710(a) (1) and (2). The setting:
• Is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
• Is selected by the individual from among setting options, including non-disability-specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
• Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.
• Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.
• Facilitates individual choice regarding services and supports and who provides them.
Respite may be provided in the participant's home, another private residence, the credentialed agency, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers. All settings mentioned above are presumed to meet HCBS compliance, since none have the qualities of an institutional setting as set forth in 42 C.F.R. § 441.530 Home and Community-Based Setting.

New HCBS providers or service settings are expected to fully comply with the HCBS requirements and qualities as a condition of becoming a Medicaid provider. The State Medicaid Agency is responsible for ongoing enforcement of quality assurance compliance.

Payments for respite services are not made for room and board.

Per 42 CFR Part 433 Subpart F, payment for respite services does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Person Centered Planning Process:
A person-centered service plan is developed using a person-centered planning process in accordance with 42 CFR §441.725(a) and (b). The State Medicaid Agency assures the person-centered planning process:
• The state provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and enables the individual to make informed choices and decisions. This is primarily from the plan facilitator and the other members of the person-centered planning team, who are selected by the participant and family.
• Includes people chosen by the individual. The individual determines who is included in the person-centered planning process. The plan facilitator elicits this information and uses it to establish necessary meetings.
• Is timely and occurs at times and locations convenient to the individual.
• Reflects the individual's cultural considerations and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited in English proficiency.
• Includes strategies for solving conflict or disagreement within the process.
• Offers choices to the individual regarding services and supports the individual receives and from whom.
Individuals are assisted in obtaining information about and selecting from among qualified service

providers. The facilitator and team support the participant in selecting among the many qualified providers available in the IBHP provider network.
• Includes a method for the individual to request updates to the plan as needed.
• Records the alternative HCBS settings that were considered by the individual.

Person Centered Plan:
The state assures the plan:
• Reflects the setting in which the individual resides is chosen by the individual
• Reflects the individual's strengths and preferences.
• Reflects clinical and support needs as identified through an assessment of functional need.
• Includes individually identified goals and desired outcomes.
• Reflects the supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of supported employment, including natural supports.
• Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
• Is understandable to the individual and the individuals supporting them.
• Identifies the individual and/or entity responsible for monitoring the plan.
• Is finalized and agreed to, with the informed consent of the individual in writing, and signed by all the individuals responsible for its implementation.
• Is distributed to the individual and other people involved in the plan.
• Prevents the provision of unnecessary or inappropriate supports.
• Documents that any modification of the additional conditions, under 42 CFR §441.710(a)(1)(vi)(A) through (D), must be supported by a specific assessed need and justified in the plan.

Additionally, the state assures the plan:
• Identifies a specific and individualized assessed need.
• Documents the positive interventions and supports used before any modifications to the person-centered service plan.
• Documents less intrusive methods of meeting the need that have been tried but did not work.
• Includes a clear description of the condition that is directly proportionate to the specific assessed need.
• Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
• Includes established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
• Includes informed consent of the individual.
• Includes an assurance that the interventions and supports will cause no harm to the individual.

Provider Qualifications:
Providers must be affiliated with a Medicaid enrolled, credentialed behavioral health agency and:
1. Be at least eighteen (18) years of age with a high school diploma or GED;
2. Have at least six (6) months' fulltime (1,040 hours) work or volunteer experience working with youth experiencing SED or SMI and their families;
3. Have the knowledge and skills to provide the service and effectively address participants' needs;
4. Successfully complete State Medicaid Agency designated training for respite care;
5. Have received classroom or on-the-job training on the following:
a. Characteristics of an SED or SMI;
b. Behavior management principles and strategies;
c. How to de-escalate and prevent, as well as manage, a crisis;
d. Confidentiality and mandated reporting requirements;
e. Basic First Aid training.

A parent/legal guardian, relative, or legally responsible individual cannot furnish respite.

*Note: There is a 1915(b)(4) that operates concurrently with this benefit.

Other 1937 Benefit Provided:
Service Coordination: Children with SHCN

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Limited to the target population

Other:

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

Other services covered by the State Medicaid Agency, but not covered by the Base Benchmark: Service Coordination for Children with Special Healthcare Needs.

Target Group:
Children under the age of twenty-one (21) who have special healthcare 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 service coordination provided to individuals in medical institutions: [Olmstead letter #3]
Target group is comprised of individuals transitioning to a community setting and targeted service coordination services will be made available for up to the last sixty (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 C.F.R. § 440.169
Service coordination is a service furnished to assist participants, eligible under the State plan, in gaining access to needed medical, social, educational and other services.

Service coordination includes the following assistance:
• Comprehensive assessment and annual reassessment of a participant to determine the need for any medical, educational, social or other services and to update the plan. These assessment activities include up to six (6) hours of:
- Taking client history;
- Identifying the participant'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 participant.

• 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 participant;

- Includes activities such as ensuring the active participation of the participant, and working with the participant (or the participant'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 participant.

• Referral and related activities:
- To help a participant obtain needed services including activities that help link the participant 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 participant.

• Monitoring and follow-up activities:
- Activities, and contacts, necessary to ensure the care plan is implemented and adequately addresses the individual's needs. These activities, and contacts, may be with the participant, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary, including at least one (1) annual monitoring to assure following conditions are met:
--Services are being furnished in accordance with the participant'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.

Service coordination may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the participant to access services.

Provider Qualifications:
• Service coordination 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 service coordinators 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 services field from a nationally accredited university or college and twelve (12) months of experience with adults with developmental disabilities; or
• Bachelor's degree in a human services field from a nationally accredited university or college, or being a licensed professional nurse (RN) with twenty-four (24) months of experience with adults with developmental disabilities.

Service Coordinator: 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 of experience working with adults with developmental disabilities, or being a licensed professional nurse (RN) with twelve (12) months of 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 service coordinator under the supervision of a qualified service coordinator 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 commensurate with the paperwork and forms involved in the provision of the service, and have twelve (12) months of experience with adults with developmental disabilities. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the service plan.

Freedom of choice: The State Medicaid Agency assures that the provision of service coordination will not restrict a participant'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.
• Participants will have free choice of the providers of service coordination within the specified geographic area identified in this plan.
• Participants will have free choice of the providers of other medical care under the plan.

Access to Services: The State Medicaid Agency assures that:
• Service coordination will be provided in a manner consistent with the best interests of participants and will not be used to restrict a participant's access to other services under the plan; [section 1902(a)(19)]
• Participants will not be compelled to receive service coordination, condition receipt of service coordination on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of service coordination; [section 1902 (a)(19)]
• Providers of service coordination do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment: 42 C.F.R. § 441.18(a)(4))
Payment for service coordination under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records: The State assures that providers maintain case records that document the following for all participants receiving service coordination (42 C.F.R. § 441.18(a)(7))
• The name of the participant.
• The dates of the service coordination services.
• The name of the provider agency and the person providing the service coordination.
• The nature, content, and units of the service coordination services received, and whether goals specified in the care plan have been achieved.
• Whether the participant has declined services in the care plan.
• The need for, and occurrences of, coordination with other service coordinators.
• A timeline for obtaining needed services.
• A timeline for reevaluation of the plan.

Limitations:
Service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 C.F.R. § 440.169 when the service coordination activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) § 4302). Service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 C.F.R. § 440.169 when the service coordination activities constitute the direct delivery of underlying medical, educational, social, or other services to which a participant 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; and making placement arrangements. (42 C.F.R. § 441.18(c))

FFP is only available for service coordination if there are no other third parties liable to pay for such services, including reimbursement under a medical, social, educational, or other program, except for service coordination 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 ongoing service coordination is not allowed prior to the completion of the

assessment and service plan.
• In order to assure that no conflict of interest exists, providers of service coordination may not provide both service coordination 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:
Skilled Nursing Facility

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
Thirty (30) days per year

Duration Limit:
None

Scope Limit:
Skilled Nursing Facility services for rehabilitation.

Other:
Program Description: Nursing facility services (other than services in an institution for mental diseases) for individuals twenty-one (21) years of age or older; § 1905(a)(4)(A) of the Act.

Services in excess of the Base Benchmark: Skilled Nursing Facility services.

The State Medicaid Agency will prior authorize services exceeding the thirty (30) day limit in the Base Benchmark when such services are determined to be medically necessary.

Other 1937 Benefit Provided:
Targeted Care Coordination Services: IBHP

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Any Idaho Behavioral Health Plan (IBHP) enrollee diagnosed with a behavioral health condition or substance use disorder who is in need of care coordination is eligible to receive this service, including, but not limited to:

1. Adults eighteen (18) and older with serious mental illness and/or substance use disorder; and
2. Children up to age twenty-one (21) with serious emotional disturbance and/or substance use disorder.

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:
Targeted Care Coordination is a service provided to assist IBHP enrollees to gain access to needed medical, social, educational, and other services, in accordance with the provisions of 42 C.F.R. § 440.169. Care coordinators also monitor the participant's progress in treatment, evaluate the effectiveness of services received under multiple providers' treatment/service plans, and track service utilization to guard against any duplication of services. Services may be delivered telephonically.

Care Coordination includes the following assistance:
• Initial assessment and annual reassessment of a participant to determine the need for any medical, educational, social or other services. More frequent reassessments may be conducted if medically necessary.
• Development (and periodic revision) of a care plan.
• Referral and related activities to help an eligible participant obtain needed services, including activities that help link an participant with Medicaid providers.
• Monitoring and follow-up activities to ensure the care plan is implemented and is adequately addressing the participant's needs.

Provider Qualifications:
This service is delivered by a qualified provider as determined by the State Medicaid Agency. Service providers must comply with the limitations of practice imposed by state law, federal regulations, State of Idaho occupational licensing requirements, the provider's professional area of competency, and applicable State Medicaid Agency rules, and qualifying criteria are subject to approval by the Department.
• Minimum Provider Qualifications for Care Coordination are providers holding at least a Bachelor's degree in a human services field and meeting the requirements of the State Medicaid Agency.

Waiver of Freedom of Choice of Providers
As permitted and authorized under section 1915(b)(4) of the Social Security Act, choice of care coordination providers is waived. Participants will have free choice of providers of other medical care under the state plan.

Freedom of Choice Exception (1915(g)(1) and 42 C.F.R. § 441.18(b)):
Providers are limited to qualified Medicaid providers of care coordination services capable of ensuring that IBHP enrollees diagnosed with a behavioral health condition or substance use disorder receive needed services and coordination of care.

Access to Services. The State assures that:
• Care coordination services will be provided in a manner consistent with the best interests of recipients and will not be used to restrict an participant's access to other services under the plan; [section 1902(a)(19)]
• Participants will not be compelled to receive care coordination services, condition receipt of care coordination services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of care coordination services; [section 1902(a)(19)]
• Providers of care coordination services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 C.F.R. § 441.18(a)(4)):
Payment for care coordination services does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 C.F.R. § 441.18(a)(7)):
The State Medicaid Agency assures that providers maintain case records that document the following for all participants receiving Care Coordination [42 C.F.R. § 441.18(a)(7)]:
• The dates of the care coordination services.

• The name of the provider agency and the person providing the care coordination services.
• The nature, content, and units of the care coordination services received, and whether goals specified in the care plan have been achieved.
• Whether the participant has declined services in the care plan.
• The need for, and occurrences of, coordination with other care coordinators.
• A timeline for obtaining needed services.
• A timeline for reevaluation of the plan.

Limitations:
Care coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 C.F.R. § 440.169 when the care coordination activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual §4302).

Care coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 C.F.R. § 440.169 when the care coordination activities constitute the direct delivery of underlying medical, educational, social, or other services to which a participant 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; and making placement arrangements. (42 C.F.R. § 441.18(c))

Providers of care coordination must deliver the service in a way that precludes conflict of interest, in accordance with 42 C.F.R. § 441.301. Providers of direct services to Medicaid participants, agencies/ entities providing direct services, and those who have an interest in or are employed by a provider of direct services cannot also deliver care coordination or person-centered service plan development, except under the circumstances set forth at 42 C.F.R. § 441.301(c)(1)(vi).

FFP is only available for care coordination services if there are no other third parties liable to pay for such services, including as reimbursed under a medical, social, educational, or other program, except for care coordination 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))

Other 1937 Benefit Provided:
Targeted Case Management: At-Risk Children

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Limited to target population.

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

Other services covered by the State Medicaid Agency, but not covered by the Base Benchmark: Targeted Case Management for At-Risk Children.

The target group consists of infant/child participants under five (5) years of age and pregnant women at risk

for abuse, neglect, and possible Child Welfare involvement.

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

Definition of services: 42 C.F.R. § 440.169
Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Targeted Case Management: At-Risk Children includes the following assistance:
• Initial comprehensive 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 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 participants, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- Assessments may be performed via home visiting and can include observations such as the presence of vision, hearing, or developmental issues to inform the care plan and facilitate referral to clinical screening

• 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, including services for the parent which are for the direct benefit of the child (for example, evidence-informed and evidence-based parenting skills);
- 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.

In the context of this Targeted Case Management target group, a parent is defined as a person who resides with a participant, provides day-to-day care, is authorized to make healthcare decisions, and is:
1. The participant's natural or adoptive parent(s);
2. A person, other than a foster parent, who has been granted legal custody of the participant; or
3. A person who is legally obligated to support the participant.

• Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with medical, social, and educational providers or other programs capable of providing needed services to address identified needs and achieve goals specified in the care plan, such as making referrals to providers for needed services and scheduling appointments for the individual, including those for the direct benefit of the child as noted above.

• 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 that 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.
- Monitoring may be performed via home visiting to include review and discussion with the beneficiary/ parent regarding progress in treatment and making necessary adjustments to the care plan based upon such

progress and changes in the individual's needs.

Targeted case management may include:
Contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Provider Qualifications
An agency qualified to be a provider of the Targeted Case Management: At-Risk Children benefit:
1) is certified in an evidence-based home visiting model approved by the State Medicaid Agency;
2) delivers services in accordance with the model in which they are certified;
3) is enrolled with the State Medicaid Agency as a Medicaid provider; and
4) has been determined to meet all requirements of the State Medicaid Agency.

An individual case manager qualified to be a provider of the Targeted Case Management: At-Risk Children benefit:
1) is certified in an evidence-based home visiting model approved by the State Medicaid Agency;
2) deliver services in accordance with the model in which they are certified;
3) is employed by a qualified agency as identified above; and
4) has been determined to meet all requirements of the State Medicaid Agency.

An evidenced-based home visiting model is an intervention in which trained home visitors meet with parents or families with young children to deliver a specified set of services through a specified set of interactions. These are voluntary interventions that are either designed or adapted and tested for delivery in the home. During the visits, home visitors aim to build strong, positive relationships with families to improve child and family outcomes. Services may be delivered on a schedule that is defined or can be tailored to meet family needs. A model has a set of standards that describe how the model is to be implemented. The model elements include one (1) or more of eight (8) outcome domains: child development and school readiness; child health; family economic self-sufficiency; linkages and referrals; maternal health; positive parenting practices; reductions in child maltreatment; and reductions in juvenile delinquency, family violence, and crime.

Freedom of choice (42 C.F.R. § 441.18(a)(1)):
The State Medicaid Agency assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan. Access to Services (42 C.F.R. § 441.18(a)(2), 42 C.F.R. § 441.18(a)(3), 42 C.F.R. § 441.18(a)(6)):

The State Medicaid Agency assures that:
• Case management services will be provided in a manner consistent with the best interests of recipients and will not be used to restrict an individual's access to other services under the plan;
• 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;
• 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 C.F.R. § 441.18(a)(4)):
Payment for case management or targeted 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 C.F.R. § 441.18(a)(7)):
The State Medicaid Agency assures that providers maintain case records that document the following for all individuals receiving case management (42 C.F.R. § 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 management services.
• The nature, content, and 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:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 C.F.R. § 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 42 C.F.R. § 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; and making placement arrangements. (42 C.F.R. § 441.18(c))

FFP is only available for case management services or targeted 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))

Other 1937 Benefit Provided:
Targeted Service Coordination: DD Adults

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Other services covered by the State Medicaid Agency, but not covered by the Base Benchmark: Targeted Service Coordination for Adults with Developmental Disabilities.

Target Group (42 C.F.R. § 441.18(a)(8)(i) and 42 C.F.R. § 441.18(a)(9):
Adults age eighteen (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 targeted service coordination provided to individuals in medical institutions: [Olmstead letter #3]
Target group is comprised of individuals transitioning to a community setting and targeted service coordination services will be made available for up to the last sixty (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 C.F.R. § 440.169)
Targeted service coordination is a service furnished to assist participants, eligible under the Idaho State Medicaid Plan, in gaining access to needed medical, social, educational and other services.

Targeted service coordination includes the following assistance:
• Comprehensive assessment and annual reassessment of a participant to determine the need for any medical, educational, social or other services and to update the plan. These assessment activities include up to six (6) hours of:
- Taking client history;
- Identifying the participant'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 participant.
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 participant;
- Includes activities such as ensuring the active participation of the participant, and working with the participant (or the participant'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 participant.

• Referral and related activities:
- To help a participant obtain needed services including activities that help link the participant 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 participant.

• Monitoring and follow-up activities:
- Activities, and contacts, necessary to ensure the care plan is implemented and adequately addresses the individual's needs. These activities, and contacts, may be with the participant, 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 participant'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.

Targeted service coordination may include contacts with non-eligible individuals that are directly related to

identifying the needs and supports for helping the participant to access services.

Provider Qualifications:
• Targeted service coordination 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 service coordinators 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 services field from a nationally accredited university or college and twelve (12) months of experience with adults with developmental disabilities; or
• Bachelor's degree in a human services field from a nationally accredited university or college, or being a licensed professional nurse (RN) with twenty-four (24) months of experience with adults with developmental disabilities.

Service Coordinator: 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 of experience working with adults with developmental disabilities, or being a licensed professional nurse (RN) with twelve (12) months of 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 service coordinator under the supervision of a qualified service coordinator 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 commensurate with the paperwork and forms involved in the provision of the service, and have twelve (12) months of experience with adults with developmental disabilities. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the service plan.

Freedom of choice: The State Medicaid Agency assures that the provision of targeted service coordination will not restrict a participant'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.
• Participants will have free choice of the providers of targeted service coordination within the specified geographic area identified in this plan.
• Participants will have free choice of the providers of other medical care under the plan.

Access to Services: The State Medicaid Agency assures that:
• Targeted service coordination will be provided in a manner consistent with the best interests of recipients and will not be used to restrict a participant's access to other services under the plan; [section 1902 (a)(19)]
• Participants will not be compelled to receive targeted service coordination, condition receipt of targeted service coordination on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of targeted service coordination; [section 1902 (a)(19)]
• Providers of targeted service coordination do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 C.F.R. § 441.18(a)(4)):
Payment for targeted service coordination under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records: The State Medicaid Agency assures that providers maintain case records that document the

following for all participants receiving targeted service coordination (42 C.F.R. § 441.18(a)(7)):
• The name of the participant.
• The dates of the targeted service coordination services.
• The name of the provider agency and the person providing the targeted service coordination.
• The nature, content, and units of the targeted service coordination services received, and whether goals specified in the care plan have been achieved.
• Whether the participant has declined services in the care plan.
• The need for, and occurrences of, coordination with other service coordinators.
• A timeline for obtaining needed services.
• A timeline for reevaluation of the plan.

Limitations:
Targeted service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 C.F.R. § 440.169 when the targeted service coordination activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) §4302). Targeted service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 C.F.R. § 440.169 when the targeted service coordination activities constitute the direct delivery of underlying medical, educational, social, or other services to which a participant 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; and making placement arrangements. (42 C.F.R. § 441.18(c))

FFP is only available for targeted service coordination if there are no other third parties liable to pay for such services, including reimbursement under a medical, social, educational, or other program except for targeted service coordination 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 ongoing service coordination is not allowed prior to the completion of the assessment and service plan.
• In order to assure that no conflict of interest exists, providers of targeted service coordination may not provide both service coordination 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:
Transition Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
Seventy-two (72) hours per benefit cycle

Duration Limit:
None

Scope Limit:
Limited to the target population.

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

Other services covered by the State Medicaid Agency, but not covered by the Base Benchmark: Transition Management services for Adults in Institutions.

Target Group (42 C.F.R. § 441.18(a)(8)(i) and 42 C.F.R. § 441.18(a)(9):
Target group includes adult individuals over the age of 18 transitioning to a community setting. Case management services will be made available after forty-five (45) consecutive days of a covered stay in a medical institution. The target group does not include individuals between the ages of twenty-two (22) and sixty-four (64) who are served in Institutions for Mental Disease or individuals who are inmates in public institutions.

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

Target group is comprised of individuals transitioning to a community setting and transition management services will be made available after all applicable Medicare Part A benefits have been exhausted.

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 C.F.R. § 440.169)
Transition management is a service furnished to assist participants, eligible under the State plan, in gaining access to needed medical, social, educational and other services.

Transition management includes the following assistance:
• Initial Comprehensive assessment of a participant to determine the need for any medical, educational, social or other services necessary to transition to the community, a home and community- based setting. The assessment is to be completed at the time of the initial referral. These assessment activities include:
-Taking client history;
-Identifying the participant'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 participant.

• Development (and periodic revision) of a specific transition care plan that:
-Is based on information collected through the assessment;
-Specifies the goals and actions to address the medical, social, educational, and other services needed by the participant to successfully transition to the community;
-Includes activities such as ensuring the active participation of the participant, and working with the participant (or the participant'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 participant related to transitioning to the community.

• Referral and related activities:
-To help a participant obtain needed services including activities that help link the participant with:
--Identifying and securing accessible home and community-based housing;
--Identifying and securing necessary and appropriate furnishings/supplies for the participant's residence;
--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 participant.

• Monitoring and follow-up activities:
-Activities, and contacts, necessary to ensure the transition care plan is implemented and adequately addresses the individual's needs. These activities, and contacts, may be with the participant, his or her

family members, providers, other entities or individuals and may be conducted as frequently as necessary, including at least one monitoring activity within twelve (12) months of discharge to assure following conditions are met:
--Services are being furnished in accordance with the participant's transition care plan;
--Services in the transition care plan are adequate; and
--If there are changes in the needs or status of the individual, necessary adjustments are made to the transition care plan and service arrangements with providers
-Monitoring will occur as part of each bureau's oversight of prior authorization and service plan oversight, in addition to being incorporated into the 1915(c) waiver programs' overall quality assurance oversight.

Transition management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the participant to access services.

The State Medicaid Agency will prior authorize services exceeding the amount limit of seventy-two (72) hours, to be used over the two (2) year benefit cycle, when such services are determined to be medically necessary. There is no hard limit/cap to use of the Transition Management benefit.

Provider Qualifications:
• Transition management must only be provided by an agency enrolled as a Medicaid provider with one of the following specialties: 1) Behavior Consultation/Crisis Management, 2) Nursing Service Agency, 3) PCS Agency, 4) PCS Case Management Agency, 5) Social Work Services, 6) TBI Agency, 7) DD (Developmental Disability) Agency, or 8) DD Case Management Agency. An agency is a business entity that provides oversight of billed transition management services.
• Any willing, qualified public or private agency may be enrolled to provide transition management services.

Transition Manager: Education
• Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college; or three (3) years of supervised work experience with the population being served.
Transition management providers will successfully complete a State Medicaid Agency approved Transition Manager training prior to providing any transition management services, which will include the following:
• Participant confidentiality – Knowledge of the limitations regarding participant information and adherence to Health Insurance Portability and Accountability Act (HIPAA) and agency confidentiality guidelines.
• Documentation – Knowledge of basic guidelines and fundamentals of documentation.
• Transition care plan development and implementation – Knowledge of development and utilization of transition care plan when delivering participant services.
• Monitoring requirements – Developing a communication plan and schedule for post-transition progress

Freedom of choice: The State Medicaid Agency assures that the provision of transition management will not restrict a participant's free choice of providers in violation of section 1902(a)(23) of the Act. Eligible participants will have a free choice of providers, the qualified home and community-based setting in which to reside, and a different transition manager if desired under the plan.

Access to Services: The State assures that:
• Transition management will be provided in a manner consistent with the best interests of recipients and will not be used to restrict a participant's access to other services under the plan; [section 1902 (a)(19)]
• Participants will not be compelled to receive transition management, condition receipt of transition management on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of transition management; [section 1902 (a)(19)]
• Providers of transition management do not exercise the agency's authority to authorize or deny the provision of other services under the plan
• Participants through the month of their twenty-first (21st) birthday, pursuant to EPSDT, may receive

additional services if determined to be medically necessary and prior authorized by the State Medicaid Agency.

Payment (42 C.F.R. § 441.18(a)(4)):
Payment for transition 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: The State assures that providers maintain case records that document the following for all participants receiving transition management services targeted service coordination (42 C.F.R. § 441.18(a)(7)):
• The name of the participant.
• The dates of the transition management services.
• The name of the provider agency and the person providing the transition management services.
• The nature, content, and units of the transition management services received, and whether goals specified in the care plan have been achieved.
• Whether the participant has declined services in the care plan.
• The need for, and occurrences of, coordination with other service coordinators.
• A timeline for obtaining needed services.
• A timeline for reevaluation of the plan.

Limitations:
Transition management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 C.F.R. § 440.169 when the transition management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) § 4302). Transition management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 C.F.R. § 440.169 when the transition management activities constitute the direct delivery of underlying medical, educational, social, or other services to which a participant 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; and making placement arrangements. (42 C.F.R. § 441.18(c))

FFP is only available for transition management if there are no other third parties liable to pay for such services, including reimbursement under a medical, social, educational, or other program. (§§1902(a)(25) and 1905(c))

Additional limitations:
• Reimbursement for ongoing transition management is not allowed prior to the completion of the assessment and transition care plan.
• To assure that no conflict of interest exists, providers of transition management may not provide both transition management services and direct services to the same Medicaid participant.

Add

☐ 15. 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

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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.

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