Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 20-0015

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

November 3, 2020

Mr. Matt Wimmer, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
P.O. Box 83720
Boise, ID 83720-0009

Dear Mr. Wimmer:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Idaho's State Plan Amendment (SPA) #20-0015, which the state submitted on August 19, 2020. The purpose of this SPA is to add Targeted Case Management (TCM) services to the state's Basic Plan. Idaho's SPA #20-0015 adds the TCM benefit for at-risk children.

SPA #20-0015 was approved on November 3, 2020, with an effective date of July 1, 2020, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Idaho State Plan.

If you have any questions regarding this amendment, please contact Laura D'Angelo at (816) 426-5925, or Laura.DAngelo1@cms.hhs.gov.

Sincerely,

[redacted]
Digitally signed by James G. Scott -S
Date: 2020.11.03 15:45:49 -06'00'

James G. Scott, Director
Division of Program Operations

Enclosures

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Idaho**

Transmittal Number:

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

ID-20-0015

Proposed Effective Date

07/01/2020 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1905 of the Social Security Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2020	$ 1971480.00
Second Year	2021	$ 1971480.00

Subject of Amendment

Adds coverage of Targeted Case Management for At Risk Children to the Basic Plan.

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 26, 2020**
Submit Date:	**Aug 19, 2020**

Alternative Benefit Plan

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

Attachment 3.1-L ☐

Alternative Benefit Plan Populations — ABP1

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

Alternative Benefit Plan Population Name: Basic Alternative Benefit Plan

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Infants and Children under Age 19	Voluntary	X
+	Former Foster Care Children	Voluntary	X
+	Extended Medicaid due to Spousal Support Collections	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Deemed Newborns	Voluntary	X
+	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Voluntary	X
+	Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	Voluntary	X
+	SSI Beneficiaries	Voluntary	X
+	Individuals Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Voluntary	X
+	Certain Individuals Needing Treatment for Breast or Cervical Cancer	Voluntary	X
+	Qualified Disabled Children under Age 19	Voluntary	X
+	Adult Group	Mandatory	X

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

Targeting Criteria (select all that apply):

☐ Income Standard.

Income Standard:

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

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

The income standard is as follows:

○ A percentage:

◉ A specific amount

The standard is as follows:

◉ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Other basis for income standard

Statewide standard			
	Household Size	Income Standard	

Additional incremental amount?

◉ Yes ○ No

Increment amount $

☐ Disease/Condition/Diagnosis/Disorder.

☐ Other.

Other Targeting Criteria (Describe):

Geographic Area

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

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

PRA Disclosure Statement

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

Alternative Benefit Plan

State Name: Idaho

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ID - 20 - 0015

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

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

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☐ Letter

☐ Email

☒ Other

Describe:

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that include informing each eligible individual of the available benefit options. Upon identification of an individual who is exempt from mandatory enrollment per 42 CFR 440.315, the Department will inform these individuals that they may choose to enroll in any plan for which they are eligible (Standard, Basic, or Enhanced), and that they may opt out of an ABP at any time and instead access Medicaid benefits under the State plan.

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

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

An attachment is submitted.

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

The state informs participants of their benefit plan options when exempt status is determined at the time of enrollment, at redetermination, upon selection of the primary care case manager, and upon request.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

The Department has an "Any Door" policy. The participant can notify their local eligibility office, their regional office, their Healthy Connections provider, or the Medicaid Central Office and obtain information about switching plans and/or initiate the process to opt out of an ABP and instead access Medicaid benefits under the State plan.

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

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

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

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

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

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other

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

☒ Copy of correspondence sent to the individual.

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

☐ Other

Alternative Benefit Plan

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

The communication text that is used to inform individuals identified as exempt, as defined under 42 CFR 440.315, about their options for enrollment is as follows:
1. You may choose any benefit plan for which you are eligible—the Standard Benefit Plan, the Basic Alternative Benefit Plan, or the Enhanced Alternative Benefit Plan.
2. You may change your choice of plans at any time by contacting the Department.

PRA Disclosure Statement

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

V.20160722

Alternative Benefit Plan

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

Attachment 3.1-L ☐

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

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

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

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

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

a) Enrollment is voluntary;

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

c) What the process is for disenrolling.

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

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

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

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

☐ Letter

☐ Email

☒ Other:

Describe:

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that include informing each eligible individual of the available benefit options. Upon identification of an individual who is exempt from mandatory enrollment per 42 CFR 440.315, the Department will inform these individuals that they may choose to enroll in any plan for which they are eligible (Standard, Basic, or Enhanced), and that they may opt out of an ABP at any time and instead access Medicaid benefits under the State plan.

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

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

An attachment is submitted.

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

The state informs participants of their benefit plan options when exempt status is determined at the time of enrollment, at

redetermination, upon selection of the primary care case manager, and upon request.

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

The Department has an "Any Door" policy. The participant can notify their local eligibility office, their regional office, their Healthy Connections provider, or the Medicaid Central Office and obtain information about switching plans and/or initiate the process to opt out of an ABP and instead access Medicaid benefits under the State plan.

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

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

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

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

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

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other:

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

☒ Copy of correspondence sent to the individual.

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

☐ Other:

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

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

The communication text that is used to inform individuals identified as exempt, as defined under 42 CFR 440.315, about voluntary enrollment is as follows:
1. You may choose any benefit plan for which you are eligible—the Standard Benefit Plan, the Basic Alternative Benefit Plan, or the Enhanced Alternative Benefit Plan.
2. You may change your choice of plans at any time by contacting the Department.

PRA Disclosure Statement

Alternative Benefit Plan

State Name: Idaho

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ID - 20 - 0015

Enrollment Assurances - Mandatory Participants ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☐ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

☐ Self-identification

☒ Other

Describe:

Part of the process of eligibility determination is the collection of eligibility and health status information. Based on that information the state will determine whether an exemption exists and allow selection of a plan voluntarily.

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☐ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☒ Provider identification

☒ Change in eligibility group

☐ Other

Alternative Benefit Plan

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ◉ Annually
- ○ Ad hoc basis
- ○ Other

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

The Department has an "Any Door" policy. The participant can notify their local eligibility office, their regional office, their Healthy Connections provider, or the Medicaid Central Office and obtain information about switching plans and/or initiate the process to opt out of an ABP and instead access Medicaid benefits under the State plan.

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

PRA Disclosure Statement

V.20160722

Alternative Benefit Plan

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

Transmittal Number: ID - 20 - 0015

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

Select one of the following:

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

Name of benefit package: Basic Alternative Benefit Plan

Selection of the Section 1937 Coverage Option

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

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

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

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

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

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

Selection of Base Benchmark Plan

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

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

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

1. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.

2. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

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

Attachment 3.1-L ☐

Alternative Benefit Plan Cost-Sharing	ABP4

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

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

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

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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V.20130807

Alternative Benefit Plan

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

Attachment 3.1-L

Benefits Description ABP5

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

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

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

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

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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

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

Secretary-Approved

Alternative Benefit Plan

☑ Essential Health Benefit 1: Ambulatory patient services Collapse All ☐

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

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Specialist Visit

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Other Practitioner Office Visit

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

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

Selected services require prior authorization.

Remove

Benefit Provided:

Outpatient Facility Fee (e.g., ASC)

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Ambulatory Surgery Center (ASC).

Selected services require prior authorization.

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Selected services require prior authorization.

Benefit Provided:

Urgent Care Centers or Facilities

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Remove

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

Benefit Provided:

Chiropractic Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

Six (6) visits per year

Duration Limit:

None

Scope Limit:

Manual manipulation of the spine to correct subluxation.

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

See "other 1937" benefits for additional services.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Renal Dialysis

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

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

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Enterostomal Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Home IV Therapy

Source: Base Benchmark Small Group

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Hospice

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Add

Alternative Benefit Plan

■ Essential Health Benefit 2: Emergency services

Collapse All ☐

Benefit Provided:
Emergency Room Services

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Emergency Transportation/Ambulance

Source:
Base Benchmark Small Group

Remove

Authorization:
Retroactive Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Add

Alternative Benefit Plan

■ Essential Health Benefit 3: Hospitalization — Collapse All ☐

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

Source: Base Benchmark Small Group

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Selected services require prior authorization.

Benefit Provided: Inpatient Physician and Surgical Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Selected services require prior authorization.

Benefit Provided: Radiation Therapy: Inpatient

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Remove

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

Add

Alternative Benefit Plan

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

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Delivery and All Inpatient Services-Maternity Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Add

Alternative Benefit Plan

Collapse All ☐

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

Benefit Provided: Substance Use Disorder Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: MH/BH Inpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Mental Health/Behavioral Health Inpatient Services.

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

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

Services are not provided in an IMD.

Benefit Provided: MH/BH Outpatient Services

Source: Secretary-Approved Other

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

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

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

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

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 MMCP ABP covers Substance Use Disorder Inpatient Services with services that are the same as the Base Benchmark, with the exception of Residential Treatment services. There are no certified Psychiatric Residential Treatment Facilities located in the State of Idaho.

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

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

Department on the first day of Medicaid responsibility.

Services are not provided in an IMD.

Remove

Benefit Provided:

Community-Based Rehabilitation Services

Source:

Secretary-Approved Other

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

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

- Interventions for psychiatric symptomatology will use an active, assertive outreach approach, including use of a comprehensive assessment and the development of a community support treatment plan, ongoing monitoring and support, medication management, skill restoration, crisis resolution and accessing needed community resources and supports.

- Interventions for substance use disorders will include substance use disorder treatment planning, psycho-education and supportive counseling, which are provided to achieve rehabilitation and sustain recovery and restoration of skills needed to access needed community resources and supports. These services are provided in conjunction with any professional or therapeutic behavioral health services identified as necessary for the participant.

- Services may be provided by one of the following contracted professionals when provided within the scope of their practice:

1) Licensed physician
2) Advanced Practice 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, are licensed or certified in their fields (i.e., Adult or Children's Certificate in Psychosocial Rehabilitation), and who meet requirements of Idaho Department of Health and Welfare or its Contractor

8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

Remove

Add

Alternative Benefit Plan

■ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

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

Coverage that exceeds the minimum requirements or other:

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

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

Alternative Benefit Plan

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

Benefit Provided: Home Health Care Services: 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: None

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

Skilled Nursing services provided through a Home Health Agency. Such services must not constitute Custodial Care, and the participant's physician must review the care at least every sixty (60) days.

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

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: Twenty (20) visits per year for rehabilitation

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 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 CFR 156.115(a)(5)(iii), Idaho Medicaid is establishing separate, equal 20-visit limits each for rehabilitation and habilitation. Services are not provided through a Home Health Agency.

All services require prior authorization.

See "Other 1937 Benefits" for additional services.

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
See below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Items that can withstand repeated use, 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.

Benefit Provided:
Skilled Nursing Facility

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Skilled Nursing Facility services for rehabilitation.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
See "Other 1937 Benefits" for services in excess of the Base Benchmark limit of 30 days per year.

Benefit Provided:
Outpatient Habilitation: OT, PT, SLP Services

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
Twenty (20) visits per year for habilitation

Duration Limit:
None

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
The Base Benchmark limit is up to 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 CFR 156.115(a)(5)(iii), Idaho Medicaid is establishing separate, equal 20-visit limits each for rehabilitation and habilitation. Services are not provided through a Home Health Agency.

Alternative Benefit Plan

All services require PA.

See "Other 1937 Benefits" for additional services.

Remove

Add

Alternative Benefit Plan

■ Essential Health Benefit 8: 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: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

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

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

Benefit Provided: Preventive Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Preventive Care/Screening/Immunization

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Diabetes Education

Source: Base Benchmark Small Group

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

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

Benefit Provided:
Tobacco Cessation Counseling

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Add

Alternative Benefit Plan

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

Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Secretary-Approved Other

Remove

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

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark

Collapse All ☐

Alternative Benefit Plan

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

Base Benchmark Benefit that was Substituted:

Residential Treatment

Source:
Base Benchmark

Remove

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

The Department substitutes Community-based Rehabilitation Services for Residential Treatment (part of the EHB 5 Mental/Behavioral Health Outpatient services and also Substance Use Disorder Inpatient services): There are no Psychiatric Residential Treatment Facilities licensed or certified in the State of Idaho.

This is an IMD.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered Collapse All ☐

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

Source:
Base Benchmark

Remove

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

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

Source:
Base Benchmark

Remove

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

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

Source:
Base Benchmark

Remove

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

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

Source:
Base Benchmark

Remove

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

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

Source:
Base Benchmark

Remove

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

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

Source:
Base Benchmark

Alternative Benefit Plan

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

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

Remove

Add

Alternative Benefit Plan

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

Other 1937 Benefit Provided:

Nursing Facility: Custodial Care

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

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

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

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

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

Other 1937 Benefit Provided:

Dental Services: Adults

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

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

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

- Oral exam every 12 months
- Cleaning every six months
- Fluoride treatment every 12 months
- Dental X-rays every 12 months (Full mouth or Panoramic every 36 months)

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

~ Dentures:
-Dentures are covered once every 5 years.

Limitations may be exceeded if medically necessary.

Exclusions - The following non-medically necessary cosmetic services are excluded from payment under the Enhanced Benchmark Benefit Package covered under the State Plan:
~ Drugs supplied to dental patients for self-administration other than those allowed by applicable Department rules.
~ Non-medically necessary cosmetic services are excluded from payment.

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

Remove

Other 1937 Benefit Provided:

Personal Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

16 hours per week

Duration Limit:

None

Scope Limit:

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

Other:

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

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

PCS include medically oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence.

The provider must deliver at least one (1) of the following services for a participant needing that service (as identified by the Department Nurse Reviewer):
a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care;
b. Assistance with bladder or bowel requirements that may include helping the participant to and from the

bathroom or assisting the participant with bedpan routines;
c. Assistance with food, nutrition, and diet activities, including preparation of meals if incidental to medical need;
d. The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the participant with developmental disabilities;
e. Assisting the participant with physician-ordered medications that are ordinarily self-administered, when the provider has completed an Idaho State Board of Nursing approved training program and in accordance with Idaho state statute and regulations governing assistance with medications;
f. Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met:
i. The task is not complex and can be safely performed in the given participant care situation;
ii. A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs;
iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly;
iv. Any change in the participant's status or problems related to the procedure must be reported immediately to the RN.

PCS may also include non-medical tasks. In addition to performing at least one (1) of the services listed above, the provider may also perform the following services, if no natural supports are available:
a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded.
b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment.
c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant.

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

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

PCS are furnished in the participant's place of residence, which may include:
• Personal Residence.
• Certified Family Home. A home certified by the Department to provide care to one (1) or two (2) adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence.
• Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner.

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

Provider Qualifications: Personal care services are provided by Licensed Professional Nurse (RN), Licensed Practical Nurse (LPN), Certified Nursing Assistant (CNA) (person listed on the CNA Registry who performs selected nursing services under the supervision of a registered professional nurse

who has successfully completed a training program and holds a Certificate of Training meeting Federal eligibility requirements for listing on the Registry) or personal assistant (must be at least eighteen (18) years of age and receive training to ensure the quality of services). Services may be provided by any qualified individual who is qualified to provide such services and who is not a member of the individual's family (legally responsible relative).

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

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

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

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

Remove

Other 1937 Benefit Provided:

Outpatient Rehab: OT, PT, and SLP

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:

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; Section 1905(a)(11) of the Act.

Services in excess of the Base Benchmark: Rehabilitation and Habilitation Services.

MMCP ABP covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark and State Plan visit limits when medically necessary.

Alternative Benefit Plan

Other 1937 Benefit Provided:

ICF/ID

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

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

Other services covered by the Department, but not covered by the Base Benchmark: ICF/ID - Intermediate Care Facility for Individuals with Intellectual Disabilities.

Other 1937 Benefit Provided:

Prescription Drugs

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Prescription Drugs: In excess of Base Benchmark.

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

The Medicare/Medicaid Coordinated Plan includes the following Medicare-excluded or otherwise restricted drugs or classes of drugs.

Prescription cough and cold symptomatic relief.

Legend therapeutic vitamins, which include injectable vitamin B-12, vitamin K and analogues, and legend folic acid;

• Oral legend drugs containing folic acid in combination with vitamin B-12 and/or iron salts, without additional ingredients; and
• Legend vitamin D and analogues.

Non-legend products, which include:
• Federal legend medications that change to non-legend status, as well as their therapeutic equivalents. The Director determines that non-legend drug products are covered based on appropriate criteria including safety, effectiveness, clinical outcomes, and the recommendation of the P&T Committee.
• Other non-legend drug products approved for coverage by the Director of the Department of Health and Welfare based on the determination of the Pharmacy and Therapeutics Committee that the non-legend product is therapeutically interchangeable with legend drugs in the same pharmacological class based on evidence comparison of efficacy, effectiveness, and safety and determined by the Department to be a cost-effective alternative.

Additional Covered Drug Products. Additional drug products will be covered as follows:
• Legend prenatal vitamins for pregnant or lactating individuals;
• Legend folic acid;
• Oral legend drugs containing folic acid in combination with vitamin B-12 and/or iron salts, without additional ingredients; and
• Legend vitamin D and analogues.

Remove

Other 1937 Benefit Provided:

Home Health Care Services

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; Section 1905(a)(7) of the Act.

Services covered in excess of the Base Benchmark: The MMCP ABP contractor covers medically necessary services in accordance with Medicare criteria.

Coverage includes:
- Home health aide services;
- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Medical and social services; and
- Medical equipment and supplies.

Other 1937 Benefit Provided:

Nursing Facility: Rehabilitation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Services in excess of the Base Benchmark: Skilled Nursing Facility (SNF).

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

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

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

Other 1937 Benefit Provided:
Podiatrist Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

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

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

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

Routine foot care is not covered.

Other 1937 Benefit Provided:
Diabetes Education

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Other

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Services in excess of the Base Benchmark: Diabetes Education.

The Base Benchmark has eliminated all amount limits for diabetes education. The MMCP ABP covers services up to the Medicare-allowed maximum of 10 hours per year.

Other 1937 Benefit Provided:
Bariatric Surgery

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

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

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

Other 1937 Benefit Provided:
Chiropractic Care

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Manual manipulation of the spine to treat a subluxation condition.

Remove

Other:

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

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

Other 1937 Benefit Provided:

Audiology

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Other 1937 Benefit Provided:

Targeted Service Coordination: Adults with DD

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

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

Target Group (42 CFR 441.18(a)(8)(i) and 441.18(a)(9)):
Adults age 18 and older, who have a developmental disability diagnosis, and who require and choose assistance to access services and supports necessary to maintain independence in the community.

For 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 60 consecutive days of the covered stay in the medical institution.

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

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

Definition of services: [42 CFR 440.169]
Targeted service coordination services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services.

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

Additional hours may be prior authorized if medically necessary.

• Development (and periodic revision) of a specific care plan that:
- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized healthcare decision-maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

• Referral and related activities:
- To help an eligible individual obtain needed services, including activities that help link the individual with:
√ Medical, social, educational providers; or
√ Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

• Monitoring and follow-up activities:
- Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals, and may be conducted as frequently as necessary, including at least one annual monitoring to assure 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.

Targeted service coordination 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.

Qualifications of providers:
• 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' experience working with adults with developmental disabilities; or
• Bachelor's degree in a human services field from a nationally accredited university or college or licensed professional nurse (RN) and twenty-four (24) months' experience working 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' experience working with adults with developmental disabilities; or be a licensed professional nurse (RN) and have twelve (12) months' experience working with adults with developmental disabilities. Individuals who meet the education or licensing requirements but do not have the required work experience may work as a 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 the level of the paperwork and forms involved in the provision of the service, and have twelve (12) months' experience with adults with developmental disabilities. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the service plan.

Freedom of choice: The State assures that the provision of targeted service coordination services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act. Any willing, qualified private agency may be enrolled as a service coordination agency.
• Eligible recipients will have free choice of the providers of targeted service coordination services within the specified geographic area identified in this plan.
• Eligible recipients will have free choice of the providers of other medical care under the plan.

Access to Services: The State assures that:
• Targeted service coordination 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; [section 1902(a)(19)]
• Individuals will not be compelled to receive targeted service coordination services, condition receipt of targeted service coordination services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of targeted service coordination services; [section 1902 (a)(19)]
• Providers of targeted service coordination services do not exercise the agency’s authority to authorize or deny the provision of other services under the plan.

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

Case Records (42 CFR 441.18(a)(7)):
The State assures that providers maintain case records that document for all individuals receiving targeted

service coordination as follows [42 CFR 441.18(a)(7)]:
• The name of the individual.
• The dates of the targeted service coordination services.
• The name of the provider agency and the person providing the targeted service coordination services.
• The nature, content, units of the targeted service coordination 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 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 §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Targeted service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the targeted service coordination 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 a 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 CFR 441.18(c))

FFP is only available for targeted service coordination 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 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 reimbursable 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.

Remove

Other 1937 Benefit Provided:
Transition Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
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 Department, but not covered by the Base Benchmark: Transition Management services for Adults in Institutions.

Target Group (42 CFR 441.18(a)(8)(i) and 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 22 and 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 CFR 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:
o Taking client history;
o Identifying the participant's needs and completing related documentation;
o Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the participant.

• Development (and periodic revision) of a specific transition care plan that:
o Is based on information collected through the assessment;
o Specifies the goals and actions to address the medical, social, educational, and other services needed by the participant to successfully transition to the community;
o 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
o Identifies a course of action to respond to the assessed needs of the participant related to transitioning to the community.

• Referral and related activities:
o 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:
o 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
o 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 Department 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.

Qualifications of providers:
• Transition management must only be provided by an agency enrolled as a Medicaid provider with one of the following specialties: Behavior Consultation/Crisis Management, Nursing Service Agency, PCS Agency, PCS Case Management Agency, Social Work Services, TBI Agency, DD (Developmental Disability) Agency, or 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 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 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 Department.

Payment (42 CFR 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 CFR 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 §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 §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 CFR 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.

Remove

Other 1937 Benefit Provided:

Targeted Case Management: At-Risk Children

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

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 Department, but not covered by the Base Benchmark: Targeted Case Management for At-Risk Children.

- The target group consists of eligible infant/child participants and parents of participants when the participant may be at risk for abuse or neglect. Priority is given to children ages zero (0) through four (4) years whose families meet screening criteria for the benefit. Pregnant individuals who meet screening criteria are also eligible to receive this benefit.

In the context of this Targeted Case Management benefit, 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.

Services to the participant's parents 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.

Priority in service delivery is given to Idaho communities and families characterized as high risk under the evidence-based criteria below. Families eligible to receive this benefit meet three (3) or more of the priority criteria listed.
* Families who reside in communities in need of such services, as measured by elevated concentrations of:
(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;
(ii) poverty;
(iii) crime;
(iv) domestic violence;
(v) high rates of high-school drop-outs;
(vi) substance abuse;
(vii) unemployment; or
(viii) child maltreatment;
* Families with pregnant individuals who have not attained age 21;
* Families that have a history of child abuse or neglect or have had interactions with child welfare services;
* Families that have a history of substance abuse or need substance abuse treatment;
* Families that have users of tobacco products in the home;
* Families that are or have children with low student achievement;
* Families with children with developmental delays or disabilities; and

* Families that include individuals who are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

~ Areas of the State in which services will be provided: Statewide

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

~ Definition of services: [42 CFR 440.169]
Targeted Case Management: At-Risk Children includes the following assistance:

• Initial assessment and annual reassessment of an individual to determine the need for any medical, educational, social or other services. More frequent reassessments may be done 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.
• Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision-maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.
• Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with medical, social, and educational providers or other programs capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
• Monitoring and follow-up activities:
- Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family participants, 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.

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.

The Targeted Case Management: At-Risk Children benefit includes assessments and screenings to determine whether the eligible infant and/or parents of the infant meet the criteria for the target population and to detect the presence of vision, hearing, or developmental issues. The benefit may also include home visits by the provider to: 1) inform the development of a care plan to address identified treatment needs; 2) observe and assess the participant's development and growth; and 3) compile information necessary to monitor the participant's progress in treatment and make necessary adjustments to the care plan based upon such progress.

~ Provider Qualifications

Qualified providers of the Targeted Case Management: At-Risk Children benefit: 1) are certified in either the Parents as Teachers (PAT) or Nurse-Family Partnership (NFP) evidence-based home visiting models; 2) deliver services in accordance with the model in which they are certified; 3) are enrolled as Medicaid providers; and 4) have been determined to meet all requirements of the Division of Medicaid.

~ Freedom of choice (42 CFR 441.18(a)(1)):
The State 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. The State 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; [section 1902 (a)(19)]
• Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]
• Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

~Payment (42 CFR 441.18(a)(4)):
Payment for case management or 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 CFR 441.18(a)(7)):
The State assures that providers maintain case records that document the following for all individuals receiving case management [42 CFR 441.18(a)(7)]:
• 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 §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) § 4302).
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(c))

FFP is only available for case management services or target case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program, except for case management that is included in an individualized education

program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Remove

Add

Alternative Benefit Plan

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

Collapse All ☐

PRA Disclosure Statement

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

V.20130808

Alternative Benefit Plan

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

Attachment 3.1-L ☐

Benefits Assurances — ABP7

EPSDT Assurances

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

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

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

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

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

○ Through an Alternative Benefit Plan.

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

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

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

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

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

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

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

Prescription Drug Coverage Assurances

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

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

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

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

Alternative Benefit Plan

Other Benefit Assurances

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

PRA Disclosure Statement

Alternative Benefit Plan

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

Attachment 3.1-L ☐

Service Delivery Systems — ABP8

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

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

Select one or more service delivery systems:

☒ Managed care.

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

☐ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

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

Managed Care Implementation

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

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

PAHP: Prepaid Ambulatory Health Plan

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

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

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

Alternative Benefit Plan

Identify the date the managed care program was approved by CMS: Jun 29, 2017

Describe program below:

Through a program known as Idaho Smiles, the Department covers dental services for eligible participants, administered through a PAHP contract. Idaho Medicaid was approved for its 1915(b) waiver for the Idaho Smiles dental pre-paid ambulatory health plan in 2015. CMS approved a renewal of the Idaho Smiles Section 1915(b) managed care waiver on June 29, 2017, with an effective period of July 1, 2017 through June 30, 2022.

The Department contracted with a single, statewide managed care entity, Managed Care North America, dba MCNA Dental, which meets the requirements of a PAHP (as defined in 42 CFR § 438.8(b)). MCNA manages a network of providers across the state in order to administer behavioral health services to eligible Medicaid participants.

Medicaid provides for an IDHW Contract Manager to to assure compliance with federal financing requirements and to lead ongoing contract administration and contract performance monitoring with overall responsibility for the management of all aspects of the contract.

Idaho Medicaid's goals for the dental program PAHP is to provide for participants' dental needs while ensuring quality service, maintaining consistency of care, maximizing use of technology, providing timely and dependable service delivery, preventing fraud and containing costs.

Idaho determines eligibility and conducts annual redetermination for every participant for ongoing Medicaid services. All participants are enrolled into the Idaho Smiles dental plan when Medicaid eligibility is established. Idaho is responsible for ongoing eligibility determinations, enrollment and dis-enrollment. The contractor provides covered services which includes equal access to services, ensures quality services, maintains consistency, contains costs, maximizes use of technology, provides timely and dependable service delivery and fraud prevention. As of June 30, 2016, the statewide provider network for rural areas consists of 195 providers in 55 locations serving 107,246 participants in urban areas, the network consists of 363 providers in 38 locations serving 179,017 participants. Overall, approximately half of all licensed dentists in the state were enrolled in 2016.

Additional Information: PAHP (Optional)

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

PRA Disclosure Statement

Alternative Benefit Plan

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Service Delivery Systems — ABP8

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

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

Select one or more service delivery systems:

☒ Managed care.

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

☐ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

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

Managed Care Implementation

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

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

PAHP: Prepaid Ambulatory Health Plan

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

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

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

Identify the date the managed care program was approved by CMS: Mar 30, 2017

Alternative Benefit Plan

Describe program below:

The Department covers community-based outpatient behavioral health services through a PAHP contract. The implementation date of the managed care delivery system was September 1, 2013. CMS approved a renewal of the IBHP Section 1915(b) managed care waiver on March 30, 2017, with an effective date of April 1, 2017 and an expiration date of March 31, 2022.

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

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

Through the implementation of a managed care system under a 1915(b) waiver, Idaho seeks to achieve the following goals:
Short-term Goals:
* Enrollment of sufficient number of competent professionals to deliver core services; Successful claims processing; Improved identification of Members who meet program qualifications for behavioral health treatment; and Successful transition process for both providers of services (agencies and individual practitioners) and participants.

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

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

Additional Information: PAHP (Optional)

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

PRA Disclosure Statement

Alternative Benefit Plan

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Service Delivery Systems — ABP8

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

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

Select one or more service delivery systems:

☒ Managed care.

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

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

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

Managed Care Implementation

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

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

PCCM: Primary Care Case Management

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

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

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

PCCM Payments

Specify how payment for services is handled:

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

Other:

Additional Information: PCCM (Optional)

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

Fee-For-Service Options

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

Traditional state-managed fee-for-service

Services managed under an administrative services organization (ASO) arrangement

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

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

Additional Information: Fee-For-Service (Optional)

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

V.20130718

Alternative Benefit Plan

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Attachment 3.1-L

Employer Sponsored Insurance and Payment of Premiums — ABP9

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

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

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

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

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

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

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

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

Alternative Benefit Plan

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General Assurances — ABP10

Economy and Efficiency of Plans

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

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

Compliance with the Law

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

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

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

PRA Disclosure Statement

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

V.20130807

Alternative Benefit Plan

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

Attachment 3.1-L ☐

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

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

An attachment is submitted.

V.20130807