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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 20-0016

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) #20-0016, 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 Enhanced Plan. Idaho's SPA #20-0016 adds the TCM benefit for at-risk children.

SPA #20-0016 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 15:55:26 -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-20-0016

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 Enhanced 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: Enhanced Alternative Benefit Plan

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Infants and Children under Age 19	Voluntary	X
+	Former Foster Care Children	Voluntary	X
+	Extended Medicaid due to Spousal Support Collections	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Deemed Newborns	Voluntary	X
+	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Voluntary	X
+	Aged, Blind 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	Voluntary	X

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

Targeting Criteria (select all that apply):

☒ Income Standard.

Income Standard:

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

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

The income standard is as follows:

○ A percentage:

◉ A specific amount

The standard is as follows:

◉ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Other basis for income standard

Statewide standard

	Household Size	Income Standard	
+	1	282	X
+	2	355	X
+	3	448	X
+	4	540	X
+	5	633	X
+	6	725	X
+	7	819	X
+	8	911	X
+	9	986	X
+	10	1,061	X

Additional incremental amount?

◉ Yes ○ No

Increment amount $ 75

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

Individuals with healthcare needs that cannot be met with the Standard State Plan
Pregnant individuals within the income limits above are eligible for full Medicaid
Pregnant individuals with incomes greater than those listed above, but below 133% FPL are eligible for pregnancy-related services
Children 0 - 6 in families with income under 142% FPL are eligible for Medicaid
Children 6 - 18 in families with income under 133% FPL are eligible for Medicaid

Alternative Benefit Plan

Deemed Newborns - Automatic Eligibility Former Foster Care Children under 26 years old, who were in Foster Care at age 18 - Automatic Eligibility Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care - Automatic Eligibility Extended Medicaid due to Spousal Support Collections - Continue with previous eligibility

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

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V.20130724

Alternative Benefit Plan

State Name: Idaho

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: ID - 20 - 0016

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

Alternative Benefit Plan

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

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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

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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

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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

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

Select one of the following:

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

Name of benefit package: Enhanced Alternative Benefit Plan

Selection of the Section 1937 Coverage Option

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

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

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

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

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

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

Selection of Base Benchmark Plan

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

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

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

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

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

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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):

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V.20130807

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Alternative Benefit Plan

State Name: Idaho

Attachment 3.1-L-

OMB Control Number: 0938-1148

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Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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

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

Secretary-Approved.

Alternative Benefit Plan

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

Benefit Provided: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Specialist Visit
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Selected services require prior authorization.

Benefit Provided: Other Practitioner Office Visit
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

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.

Remove

Benefit Provided: Outpatient Surgery Physician/Surgical Services

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Selected services require prior authorization.

Remove

Benefit Provided: 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

Alternative Benefit Plan

Scope Limit:

None

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

Benefit Provided:

Chiropractic Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

Six (6) visits

Duration Limit:

None

Scope Limit:

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

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

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

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Renal Dialysis

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Respiratory Therapy

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Enterostomal Therapy

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Home IV Therapy

Source:
Base Benchmark Small Group

Remove

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Hospice

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Concurrent care for children under the age of 21 is covered.

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

Add

Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided: Emergency Room Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Emergency Transportation/Ambulance

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Remove

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

Source: Base Benchmark Small Group

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Inpatient stays are reviewed by the Department or its contractor after three days, or in four days if the participant has had a cesarean section.

Selected services require prior authorization.

Remove

Benefit Provided: Inpatient Physician and Surgical Services

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Selected services require prior authorization.

Remove

Benefit Provided: Radiation Therapy: Inpatient

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

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

Add

Alternative Benefit Plan

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

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

See "Other 1937 Benefits" for additional provider types covered beyond the Base Benchmark: Other Licensed Practitioner, Licensed Midwife.

Coverage includes all necessary prenatal care, delivery, postpartum care, and family planning services.

Idaho does not cover services for pregnant individuals that are medically contraindicated during pregnancy, elective procedures, or procedures that may threaten the carrying of the fetus to full term.

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

Add

Alternative Benefit Plan

Collapse All ☐

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

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

Remove

Benefit Provided: Substance Use Disorder Outpatient Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Qualified Providers:
1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Providers who hold at least a Bachelor's degree, a Certification or Licensing in their field, and meet requirements of Idaho Department of Health and Welfare
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

Remove

Benefit Provided: MH/BH Inpatient Services

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Alternative Benefit Plan

Remove

Benefit Provided:
Substance Use Disorder Inpatient Services

Source:
Secretary-Approved Other

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Remove

Benefit Provided:
Partial Care

Source:
Secretary-Approved Other

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Program Description: Partial Care Treatment; 1905(a)(6) of the Act.

* Services are prior authorized, and there is no limitation in amount, duration or scope.

* A distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care that is reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or reduce disability or restore the individual's condition and functional level and to prevent relapse or hospitalization. These services occur through the application of principles of behavior modification for behavior change and structured, goal-oriented group socialization for skill acquisition.

* Partial Care is a program of services that include support therapy, medication monitoring, and skills building as appropriate for the individual. Each service must be delivered by a person licensed or certified to deliver those services.

Partial Care treatment may be provided by one of the following contracted licensed or certified professionals within the scope of their practice:
1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker

5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Providers who hold at least a Bachelor's degree and are Licensed Social Workers
8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
9) Registered Nurse

- These licensed practitioners provide supervision to unlicensed practitioners, including certified alcohol and drug counselors.
- Such supervision is included in the State's Scope of Practice Act for the supervising licensed practitioner.
- The licensed practitioner assumes professional responsibility for the services provided by the unlicensed practitioner.

Remove

Benefit Provided: Psychotherapy: Individual, Family, and Group

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Remove

Benefit Provided: MH/BH Outpatient Services: ECT Therapy

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Medication Management

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:

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

Benefit Provided: Intensive Outpatient Program, MH and SUDs

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: IOP services do not include overnight housing.

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

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

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

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

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

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

Due to the non-residential nature of the program, IOP services are commonly provided during evenings and on weekends. Because IOP programs have such a different approach and intensity, they are not typically designed to be used for extended duration; instead they rely on an integrated approach using high-frequency contact to increase functioning, monitor and maintain stability, and support recovery.

Following the participant's admission to IOP, it is not appropriate for other behavioral health providers to provide services to the participant or bill for services outside the program, with the exception of psychiatric services and medication management. All other services are included in the IOP's per diem rate.

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

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

Benefit Provided: Psychological/Neuropsychological Testing

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit:

None

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

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

Remove

Benefit Provided:

Skills Building/CBRS: Adults

Source:

Base Benchmark Small Group

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

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

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

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

Skills Building/CBRS is appropriate for adults receiving treatment for a Severe and Persistent Mental Illness (SPMI) or Serious Mental Illness (SMI) when they have been assessed to have at least two (2) significant functional deficits related to the identified SPMI/SMI, and Skills Building/CBRS services are

necessary in order for the adult to obtain and/or apply developmentally age-appropriate skills.

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

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

Licensed clinicians qualified for independent practice in the State of Idaho may provide Skills Building/ CBRS services without the need to obtain a PRA credential. Paraprofessional providers who do not hold a current PRA credential and were hired on or after November 1, 2010, may deliver this service for a period not to exceed thirty (30) months from the initial date of hire. This thirty-month (30) period does not restart with new employment as a Skills Building/CBRS specialist when transferring to a new employer or agency. The provider must show documentation that they are working towards obtaining the required PRA credential. In order to continue providing this service as a Skills Building/CBRS specialist beyond the 30-month period, the paraprofessional provider must have obtained the required current PRA credential.

Benefit Provided: Skills Building/CBRS: Children

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

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

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

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

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

Licensed clinicians qualified for independent practice in the State of Idaho may provide Skills Building/CBRS services without the need to obtain a PRA credential. Paraprofessional providers who do not hold a current PRA credential and were hired on or after November 1, 2010, may deliver this service for a period not to exceed thirty (30) months from the initial date of hire. This thirty-month (30) period does not restart with new employment as a Skills Building/CBRS specialist when transferring to a new school district, charter school, or agency. The provider must show documentation that they are working towards obtaining the required PRA credential. In order to continue providing this service as a Skills Building/CBRS specialist beyond the 30-month period, the paraprofessional provider must have obtained the required current PRA credential.

Alternative Benefit Plan

Remove

Benefit Provided:
Partial Hospitalization, MH and SUDs

Source:
Base Benchmark Small Group

Authorization:
None

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

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

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

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

Partial Hospitalization is appropriate for participants who are experiencing symptoms that can be addressed and managed in a level of care that is less intensive than psychiatric hospitalization but who require a higher level of care than routine outpatient or other intensive services. This service may function as a step-down option from psychiatric hospitalization or residential treatment, and may also be used to prevent or minimize the need for a more intensive level of treatment. A participant may be admitted to the program when the participant cannot be safely and appropriately treated in a less restrictive level of care.

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

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

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

Provider Qualifications
Partial Hospitalization services may be provided by the following contracted professionals within the scope of their practice:

1) Licensed physician
2) Advanced Practice Registered Nurse
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
7) Registered Nurse

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

Add

Alternative Benefit Plan

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

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

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

Coverage that exceeds the minimum requirements or other:

The Department covers at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class.

Prior Authorization criteria are developed by the Department's clinical pharmacists with input from the Medical Director, the Pharmacy and Therapeutics Committee, and the Drug Utilization Review Board. The criteria used to place drugs on prior authorization are based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug, and quality evidence provided by established drug compendia, and the Drug Effectiveness Review Program.

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

Alternative Benefit Plan

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

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

Benefit Provided: Home Health Care Services: Skilled Nursing

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Skilled Nursing services provided through a Home Health Agency.

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

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

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

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

Duration Limit: None

Scope Limit: PT, OT, SLP rehabilitation services are for the purpose of restoring certain functional losses due to disease, illness, or injury.

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

The Base Benchmark limit is up to 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.

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

Benefit Provided: Habilitation Services

Source: Base Benchmark Small Group

Remove

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

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

Duration Limit:
None

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

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
The Base Benchmark limit is up to 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.

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

Remove

Benefit Provided:
Durable Medical Equipment

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

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

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

Remove

Benefit Provided:
Skilled Nursing Facility

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
30 days per year

Duration Limit:
None

Scope Limit:
Skilled Nursing Facility services for rehabilitation.

Alternative Benefit Plan

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

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

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

Add

Alternative Benefit Plan

■ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

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

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

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

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

Remove

Benefit Provided: Preventive Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Remove

Benefit Provided: Preventive Care/Screening/Immunization

Source: Secretary-Approved Other

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Coverage includes the following:
- Health Risk Assessment, which consists of:
• An initial health questionnaire; and
• A well child screen; or
• An adult physical.

- The health questionnaire is designed to assess the general health status and health behaviors of a recipient. This information will be used to provide customized health education. The health questionnaire will be administered at initial program entry and periodic intervals thereafter.
- A well child screen or adult physical conducted at periodic or interperiodic intervals which constitutes a health risk assessment will consist of a comprehensive physical examination and health education.

The Well Child Screen includes periodic medical screens and services completed at intervals recommended by the U.S. Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

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

Remove

Benefit Provided: Diabetes Education

Source: Base Benchmark Small Group

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: 24 hrs group sessions + 12 hrs individual per 5 yr

Duration Limit: None

Scope Limit: None

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

Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. More can be authorized when medically necessary.

Remove

Benefit Provided: Tobacco Cessation Counseling

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Covered in accordance with USPSTF recommendations.

Remove

Benefit Provided: Dietary Counseling

Source: Secretary-Approved Other

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:

Two (2) visits per year

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

■ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided: Medicaid State Plan EPSDT Benefits
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

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

Selected services require prior authorization.

Benefit Provided: Medicaid State Plan EPSDT Benefits
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

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

Benefit Provided: Medicaid State Plan EPSDT Benefits
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

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

Participants who have been diagnosed with a visual defect and who need eyeglasses for correction of a refractive error can receive one (1) pair of single vision or bifocal eyeglasses annually. Frames or lenses may be provided more frequently when medically necessary.

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Selected services require prior authorization.

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Selected services require prior authorization.

Add

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

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

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

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

Source: Base Benchmark

Remove

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

Add

Alternative Benefit Plan

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

Remove

Other 1937 Benefit Provided:
Licensed Midwife

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

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

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

Other services covered by the Department, but not covered by the Base Benchmark: Licensed Midwife (LM).

LM services include maternal and newborn care provided by LM providers within the scope of their practice and who are licensed by the Idaho Board of Midwifery.

Remove

Other 1937 Benefit Provided:
Optometrist and Ophthalmologist Services: Adults

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
One pair glasses or contacts post cataract surgery

Duration Limit:
None

Scope Limit:
None

Other:
Program Description:
* Physician Services; 1905(a)(5)(A) of the Act; and
* Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law; 1905(a)(6) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Optometrist and Ophthalmologist Services for adults.

The Department will cover services to monitor conditions that may cause damage to the eye and acute conditions that without treatment may cause permanent damage to the eye. One pair of glasses or contacts is covered post cataract surgery.

Other 1937 Benefit Provided:
Dental Services: Adults

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

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

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

Adult individuals receive all medically necessary preventative and restorative dental services, including:
* Preventive dental services:
- Oral exam every 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 7 years
Limitations may be exceeded if medically necessary.

Exclusions:
* Drugs supplied to dental patients for self-administration other than those allowed by applicable Department rules.
* Non-medically necessary cosmetic services.

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

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Retroactive Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services are for the purpose of restoring certain functional losses due to disease, illness, or injury.

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

Services in excess of the Base Benchmark: Rehabilitation Services.

The Department covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark aggregate 20 visit limit. Claims exceeding current Medicare dollar caps are subject to targeted review for medical necessity.

Remove

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Retroactive Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services for developing skills and functional abilities necessary for daily living and skills related to communication of persons who have never acquired them.

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

Services in excess of the Base Benchmark: Habilitation Services.

The Department covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark aggregate 20 visit limit. Claims exceeding current Medicare dollar caps are subject to targeted review for medical necessity.

Remove

Other 1937 Benefit Provided:
Bariatric Surgery

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

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

Other 1937 Benefit Provided:

Prescription Drugs

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

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

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

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

| | (D) Agents when used for the symptomatic relief of cough and colds.

| X | (E) Agents when used to promote smoking cessation.

| X | (F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations. Covered agents include: Injectable vitamin B12 (cyanocobalamin and analogues); vitamin K and analogues; prescription vitamin D and analogues; prescription pediatric vitamin-fluoride preparations; prescription pediatric vitamins, minerals, and flouride preparations; prenatal vitamins for pregnant or lactating individuals; prescription vitamin D and analogues; prescription folic acid; and oral prescription drugs containing folic acid in combination with vitamin B12 and/or iron salts, without additional ingredients.

| X | (G) Nonprescription drugs, except, in the case of pregnant women when recommended in accordance with Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposed of promoting, and when used to promote, tobacco cessation.

Certain prescribed non-prescription products are covered, including: Permethrin; oral iron salts; disposable insulin syringes and needles; insulin; and tobacco cessation products.

| | (H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

| X | (I) Barbiturates

| X | (J) Benzodiazepines

| | (K) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

Additional Excluded Drugs

Drugs are also not covered when the following circumstances apply:

• The participant’s practitioner has written an order for a prescription drug for which federal financial participation is not available.

• The participant's practitioner has written an order for a prescription drug that is deemed to be experimental or investigational, as defined in IDAPA 16.03.09.390.03. Investigational drugs are not a covered service under the Idaho Medicaid pharmacy program. The Idaho Department of Health and Welfare may consider Medicaid coverage on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available.
• The participant's practitioner has written an order for a covered outpatient drug for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
• The Idaho Medicaid Pharmacy Program receives a provider reimbursement claim for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment.
• The participant is dually eligible for Medicare and Medicaid, and the prescribed drug or drug class is covered under Medicare Part D. In the case of dual eligibles, the Department will pay for only those Medicaid-covered drugs not covered under Medicare Part D.

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

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

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

Other 1937 Benefit Provided:
Preventive Health Assistance

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Individualized benefits for individuals who are obese to address target health behaviors.

Other:
Program Description: This benefit is one of many preventive benefits that are included in this ABP. This benefit is covered in addition to the prevention and wellness benefits found in EHB 9 and is being approved as Secretary-Approved Coverage.

Other services covered by the Department, but not covered by the Base Benchmark: Preventive Health Assistance.

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

PHA benefits are individualized benefits to address target health behaviors. Authorizations will be managed by the State Medicaid agency. PHA benefits made available under this plan will target individuals who are obese.

PHA benefits will be available when individuals complete specified activities in preparation for addressing the target health condition. These activities include discussing the condition with their primary care provider, participating in an applicable support group, and completing basic educational materials related to the condition.

PHA benefits may be used to purchase goods and services related to weight reduction/management rules. These goods and services may include weight-loss programs, dietary supplements, and other health-related benefits.

Remove

Other 1937 Benefit Provided:
Home Health Care Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
100 visits per year

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: Home Health Care Services; 1905(a)(7) of the Act.

Services covered in excess of the Base Benchmark: The Base Benchmark covers up to 20 visits per year combined for outpatient PT/OT/SLP services.

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

Remove

Other 1937 Benefit Provided:
Durable Medical Equipment

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: Home health care services; 1905(a)(7) of the Act.

Services in excess of the Base Benchmark: DME.
- The Department covers some items not covered by the Base Benchmark.
- The Department will replace DME more frequently than five (5) years when determined to be medically necessary.

Other 1937 Benefit Provided:

Podiatrist Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

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.

Routine foot care is not covered.

Other:

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

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

Other 1937 Benefit Provided:

Individual and Family Medical Social Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Other

Amount Limit:

Two (2) visits

Duration Limit:

Scope Limit:

None

Other:

Program Description: Medical Care; 1905(a)(6) – Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

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

Payment is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Board of Social Work Examiners. Additional services may be prior authorized.

Remove

Other 1937 Benefit Provided:
Targeted Care Coordination Services: IBHP

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

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

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

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

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

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

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

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

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

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

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

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

Care coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the care coordination activities constitute the direct delivery of underlying medical, educational, social, or other services to which a participant has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(c))

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

FFP is only available for care coordination services if there are no other third parties liable to pay for such services, including as reimbursed under a medical, social, educational, or other program, except for care coordination that is included in an individualized education program or individualized family service plan

consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Other 1937 Benefit Provided: Dentures

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

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

Duration Limit: None

Scope Limit:

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

Other:

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

Other 1937 Benefit Provided: Audiology

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other:

Certain services require prior authorization.

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

Other 1937 Benefit Provided: Behavioral Consultation

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

36 hours per student per year

Duration Limit:

None

Scope Limit:

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

Other:

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

- Behavioral consultation supports a multi-disciplinary approach to rehabilitative and treatment by consulting with the IEP team during the assessment process for a specific child, performing advanced assessment of the child, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members for a child's needs.

Behavioral consultation provides expertise for children with complex needs who are not demonstrating outcomes with behavioral interventions alone. The consultant works with the IEP team and other professionals to develop a positive behavior support plan and provide oversight in carrying out that plan to reduce disability and increase function.

- Qualifications for Behavioral Consultation providers are:
~ Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or in a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program), and who meets one (1) of the following:
~ An individual with an Exceptional Child Certificate as defined by State law.
~ An individual with an Early Childhood/Early Childhood Special Education Blended Certificate as defined by State law.
~ A Special Education Consulting Teacher as defined by State law.
~ An individual with a Pupil Personnel Certificate as defined by State law, excluding a registered nurse or audiologist.
~ An occupational therapist who is qualified and registered to practice in Idaho.
~ Therapeutic consultation professional who meets the requirements defined by the Department.

- Services provided in the schools must be the same in amount, duration and scope as the services provided in the community.
- Individuals delivering services in the schools must adhere to the same provider qualifications as required for individuals delivering services in the community.
- Participants are able to choose to receive Medicaid services from the pool of qualified Medicaid providers, which includes school-based and community providers.
- Participants through the month of their twenty-first (21st) birthday, pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Other 1937 Benefit Provided:

Behavioral Intervention

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

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

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

Services may include individual or group services. Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) individuals. As the number and needs of the participants increase, the participant ratio in the group must be adjusted from three (3) to two (2). Group services should only be delivered when the participant's goals relate to benefiting from group interaction.

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

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

Remove

Other 1937 Benefit Provided:
Nursing Facility: Custodial Care

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

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

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

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

This service is not covered by the Base Benchmark. The Department requires that the nursing facility services include at least the items and services specified in 42 CFR 483, including 42 CFR 483.10(c)(8)(i).

Remove

Other 1937 Benefit Provided:

Private-Duty Nursing

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Nursing services provided by a licensed registered nurse or licensed practical nurse to a non-institutionalized child under the age of 21 requiring care for conditions of such medical severity or complexity that skilled nursing is necessary.

Other:

Program Description: Private-Duty Nursing (PDN); 1905(a)(8) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Private-Duty Nursing (PDN).

Medical severity and complexity means that the child requires more individual and continuous care than is available from a visiting nurse and the needed services cannot safely be delegated to an Unlicensed Assistive Personnel.

The nursing needs must be of such a nature that the Idaho Nursing Practice Act, rules, regulations, or policy require the service to be provided by an Idaho Licensed Registered Nurse (RN), or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from Home Health skilled nursing services. All PDN services are ordered by a physician and provided under a written plan of care.

Limitations. The following service limitations apply to the Enhanced Alternative Benefit Plan covered under the State plan.
• PDN services must be authorized by the Department or its authorized agent prior to delivery of service.
• PDN Services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. If service is requested only to attend school or other activities outside of the

home, but the child does not need such services in the home, private duty nursing will not be authorized.
The following are specifically excluded as personal residences:
• Licensed Nursing Facilities (NF);
• Licensed Intermediate Care Facilities for the Intellectually Disabled (ICF/ID);
• Licensed Residential Care Facilities;
• Licensed hospitals; and
• Public or private schools.

Other 1937 Benefit Provided:
Personal Care Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Medically oriented care services related to a participant's physical or functional requirements provided in the participant's home or personal residence. Children may also receive PCS as a school-based service.

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

Other services covered by the 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 a 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 in accordance with Idaho state statute and regulations governing assistance with medications;
f. Non-nasogastric gastrostomy tube feedings, if authorized by RMS prior to implementation and if the following requirements are met:
i. The task is not complex and can be safely performed in the given participant care situation;
ii. A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs;
iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing

the procedure, and evaluate the performance of the procedure at least monthly;
iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN.

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

Services are furnished to a participant who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the intellectually disabled, or institution for mental diseases.

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

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

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

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

Provider Qualifications: Personal care services are provided by Licensed Professional Nurse (RN), Licensed Practical Nurse (LPN), Certified Nursing Assistant (CNA), a person listed on the CNA Registry

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

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

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

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

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

Individuals 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.

Other 1937 Benefit Provided:

Targeted Service Coordination: DD Adults

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: Targeted Case Management Services; 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 is a service furnished to assist participants, eligible under the State plan, in gaining access to needed medical, social, educational and other services.

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

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

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

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

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

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

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 of experience with adults with developmental disabilities; or
• Bachelor's degree in a human services field from a nationally accredited university or college, or being a licensed professional nurse (RN) with twenty-four (24) months of experience with adults with developmental disabilities.

Service Coordinator: Education and Experience
• Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and twelve (12) months of experience working with adults with developmental disabilities, or being a licensed professional nurse (RN) with twelve (12) months of experience working with adults with developmental disabilities. Individuals who meet the education or licensing requirements, but do not have the required work experience, may work as a service coordinator under the supervision of a qualified service coordinator while they gain this experience.

Paraprofessional: Education and Experience
• Be at least eighteen (18) years of age, have a minimum of a high school diploma (or equivalency), be able to read and write at a level commensurate with the paperwork and forms involved in the provision of the service, and have twelve (12) months of experience with adults with developmental disabilities. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the service plan.

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

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

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

Case Records: The State assures that providers maintain case records that document the following for all

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

Limitations:
Targeted service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the targeted service coordination activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) §4302). Targeted service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the targeted service coordination activities constitute the direct delivery of underlying medical, educational, social, or other services to which a participant has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(c))

FFP is only available for targeted service coordination if there are no other third parties liable to pay for such services, including reimbursement under a medical, social, educational, or other program except for targeted service coordination that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Additional limitations:
• Reimbursement for ongoing service coordination is not allowed prior to the completion of the assessment and service plan.
• In order to assure that no conflict of interest exists, providers of targeted service coordination may not provide both service coordination and direct services to the same Medicaid participant.
• Reimbursement is not allowed for missed appointments, attempted contacts, leaving messages, travel to provide the service, documenting services, or transporting the participant.

Remove

Other 1937 Benefit Provided:
Service Coordination: Children with SHCN

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Limited to the target population

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

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

Target Group:
Children under the age of 21 who have special healthcare needs requiring medical and multidisciplinary rehabilitation services, and who require and choose assistance to access services and supports necessary to maintain independence in the community.

For service coordination provided to individuals in medical institutions: [Olmstead letter #3]
Target group is comprised of individuals transitioning to a community setting and targeted service coordination services will be made available for up to the last 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]
Service coordination is a service furnished to assist participants, eligible under the State plan, in gaining access to needed medical, social, educational and other services.

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

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

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

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

plan and service arrangements with providers.

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

Qualifications of providers:
• Service coordination must only be provided by a service coordination agency enrolled as a Medicaid provider. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor, and a minimum of one (1) service coordinator.
• Agencies must provide supervision to all service coordinators and paraprofessionals.
• Any willing, qualified public or private service coordination agency may be enrolled.

Agency Supervisor: Education and Experience
• Master's Degree in a human services field from a nationally accredited university or college and twelve (12) months of experience with adults with developmental disabilities; or
• Bachelor's degree in a human services field from a nationally accredited university or college, or being a licensed professional nurse (RN) with twenty-four (24) months of experience with adults with developmental disabilities.

Service Coordinator: Education and Experience
• Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and twelve (12) months of experience working with adults with developmental disabilities, or being a licensed professional nurse (RN) with twelve (12) months of experience working with adults with developmental disabilities. Individuals who meet the education or licensing requirements, but do not have the required work experience, may work as a service coordinator under the supervision of a qualified service coordinator while they gain this experience.

Paraprofessional: Education and Experience
• Be at least eighteen (18) years of age, have a minimum of a high school diploma (or equivalency), be able to read and write at a level commensurate with the paperwork and forms involved in the provision of the service, and have twelve (12) months of experience with adults with developmental disabilities. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the service plan.

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

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

Payment (42 CFR 441.18(a)(4)):
Payment for service coordination under the plan does not duplicate payments made to public agencies or

private entities under other program authorities for this same purpose.

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

Limitations:
Service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the service coordination activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) § 4302). Service coordination does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the service coordination activities constitute the direct delivery of underlying medical, educational, social, or other services to which a participant has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(c))

FFP is only available for service coordination if there are no other third parties liable to pay for such services, including reimbursement under a medical, social, educational, or other program, except for service coordination that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

Additional limitations:
• Reimbursement for ongoing service coordination is not allowed prior to the completion of the assessment and service plan.
• In order to assure that no conflict of interest exists, providers of service coordination may not provide both service coordination and direct services to the same Medicaid participant.
• Reimbursement is not allowed for missed appointments, attempted contacts, leaving messages, travel to provide the service, documenting services, or transporting the participant.

Other 1937 Benefit Provided: ICF/ID

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications:

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

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

The 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 the Intellectually Disabled.

Other 1937 Benefit Provided: Nursing Facility: Rehabilitative

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: 30 days per year

Duration Limit:

Scope Limit: Skilled Nursing Facility services for rehabilitation.

Other:

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

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

The Base Benchmark covers nursing facilities for rehabilitation and limits care to 30 days per year for only certain conditions. The Department will cover rehabilitative skilled nursing facility services in excess of the 30 days per year covered by the Base Benchmark if the participant is showing progress toward rehabilitation goals.

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

The Department requires that the nursing facility services include at least the items and services specified in 42 CFR 483 including 42 CFR 483.10(c)(8)(i).

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

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: Inpatient Services for participants age 65 and over in an Institution for Mental Diseases.

Other:

Program Description: In addition to psychiatric services covered under Inpatient Hospital Services, the Enhanced Alternative Benefit Plan includes services for certain individuals in Institutions for Mental Diseases permitted under sections 1905(a)(14) of the Social Security Act.

Other services covered by the Department, but not covered by the Base Benchmark: Inpatient hospital services for individuals age 65 or over in Institutions for Mental Diseases.

The State assures that requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

The Department provides assurance that providers of inpatient psychiatric services for individuals under 21 shall meet the requirements of 42 CFR 440.160(b) and Subpart D of 42 CFR 441 regarding certification and accreditation requirements.

The Department provides assurance that inpatient psychiatric services for individuals under 21 comply with restraint and seclusion requirements at 42 CFR 483 Subpart G.

Remove

Other 1937 Benefit Provided:

Early Intervention Services (EIS)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Other:

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

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

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

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

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

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

Other 1937 Benefit Provided:
Peer Support, including Youth Support

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Peer Support includes Adult Peer Support, Recovery Coaching and Youth Support. Adult Peer Support is a face-to-face recovery support service in which a Certified Peer Support Specialist mentors, guides and coaches the participant to achieve self-identified recovery and resiliency goals. This service is typically delivered to adults with a serious mental illness or co-occurring mental health and substance use disorders who are actively involved in their own recovery process. This specialized support is intended to complement an array of therapeutic services and may be offered before, during, or after mental health treatment has begun to facilitate long-term recovery in the community.

Peer support providers serving participants whose primary diagnosis is SUD are known as Recovery Coaches (RCs). The RC serves as a personal guide and mentor for participants in recovery, helping to remove barriers and obstacles, linking participants to services, supports, and the recovery community. Following any episodes of drug or alcohol use or lapses in recovery, the RC works to achieve quick turnaround in re-engaging the individual in treatment and/or recovery support. The efforts of the RC decrease substance use, number and severity of relapse episodes, and criminal justice involvement.

In collaboration with the participant, the Peer Support Specialist/RC will create an individualized recovery plan that reflects the participant's needs and preferences, and describes the participant's individualized goals, interventions, timeframes and measurable results. The recovery plan will be formally reviewed at least every three (3) months.

Components of this service may include:
• Assistance with setting recovery goals, developing a recovery action plan, a relapse plan, solving problems and addressing barriers related to recovery;
• Encouraging self-determination, hope, insight, and the development of new skills;
• Connecting the participant with professional and non-professional recovery resources in the community and helping the participant navigate the service system in accessing resources independently;
• Facilitating activation so that participants may effectively manage their own mental illness or co-occurring conditions, and empowering participants to engage in their own treatment, healthcare and recovery;
• Helping the participant decrease isolation and build a community supportive of the participant establishing and maintaining recovery.

Youth Support services are provided by younger adults with lived experience of serious emotional disturbance (SED) during childhood/adolescence to assist and support participants in understanding their role in accessing services, and in becoming informed consumers of services and self-advocates. Youth support may include mentoring, advocating, and educating provided through youth support groups. Participants receiving this service will work on goals within their group, which will consist of four (4) or more participants.

In addition to the mandatory SED diagnosis, participants may also have a co-occurring substance use disorder or developmental disability. This service is covered for children through the month of their twenty-first (21st) birthday when medically necessary.

Provider Qualifications
Qualified Adult Peer Support providers must have obtained certification as a Peer Support Specialist. The Peer Support Specialist is supervised by a competent mental health practitioner.

Provider qualifications for Recovery Coaches (RCs) are as follows:
• Certified Peer Recovery Coaches (CPRCs) are self-identified persons in recovery who have at least a high school diploma or GED, have 500 hours of paid or volunteer recovery support experience (including supervision hours), have completed 46 hours of education/training related to the CPRC domains, and meet all other requirements established for certification by the Idaho Board of Alcohol/Drug Counselor

Certification (IBADCC).
• Provisional Certified Peer Recovery Coaches (PCPRCs) meet the same qualifications as CPRCs, but are working toward the 500 hours of experience requirement and passing the required exam.
• Certified Recovery Coaches (CRCs) are not self-identified persons in recovery, but they meet all of the other requirements for CPRC certification described above.
• Provisional Certified Recovery Coaches (PCRCs) meet the same qualifications as CRCs, but are working toward the 500 hours of experience requirement and passing the required exam.

The Youth Support Specialist is supervised by a competent mental health practitioner, and will meet the following requirements:
1. High school diploma or GED
2. Diagnosed with SED as a young adult
3. Was transitioned out of treatment at least one year ago
4. 18 years of age or older
5. Must have obtained certification as a Peer Support Specialist
6. Completion of endorsement as a Youth Support Specialist

Other 1937 Benefit Provided:

Care Planning through Child and Family Team (CFT)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

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

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

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

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

Other 1937 Benefit Provided:
Crisis Response

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

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

• Functionally or physically impaired;
• Extremely distraught and out of control; or
• Severely impaired by drugs or alcohol.

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

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

Remove

Other 1937 Benefit Provided:
Family Psychoeducation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

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

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

Provider Qualifications

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

Other 1937 Benefit Provided:

Crisis Intervention

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

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

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

Provider Qualifications
Any providers of this service will be required to obtain certification in Crisis Response and Intervention by the Crisis Prevention Institute (CPI). The team typically includes a Master's-level clinician (Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Clinical Professional Counselor) and a Bachelor's-level paraprofessional with a degree in a human services field plus CPI certification, supervised by a Master's-level Clinical Supervisor with CPI certification.

Other 1937 Benefit Provided:
Family Support

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

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

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

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

Other 1937 Benefit Provided:
Behavior Modification and Consultation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

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

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

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

Behavior modification services typically include development, implementation and monitoring of a behavioral management plan and other rehabilitation services identified in the behavior management plan. Once the behavior management plan is implemented, behavioral strategies can alter or improve specific behaviors when consistently applied by family members, teachers, and professional therapists working in concert with the participant until the behavior is effectively managed.

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

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

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

Other 1937 Benefit Provided:
Transition Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

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.

Other 1937 Benefit Provided:
Habilitative Skill Building

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

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

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

Services may include individual or group interventions. Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) participants. As the number and needs of the participants increase, the participant ratio in the group must be adjusted from three (3) to two (2). Group services should only be delivered when the participant's goals relate to benefiting from group interaction. Habilitative skill building may include interdisciplinary training to assist with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is intended to be utilized for collaboration, with the participant present, during the provision of services between a bachelor's-level intervention provider or Master's-level intervention provider and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional or behavioral/mental health professional. A bachelor's-level may provide this service if they meet the supervisory protocol required.

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

Remove

Other 1937 Benefit Provided:
Children's Habilitation Crisis Intervention

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

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

Other:

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

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

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

Remove

Other 1937 Benefit Provided:
Case Management Services: IBHP

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Any Idaho Behavioral Health Plan (IBHP) enrollee diagnosed with a mental health or substance use disorder who is in need of case management is eligible to receive this service.

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

~ Definition of services: [42 CFR 440.169]
IBHP case management services are furnished to participants who require access to behavioral, medical, and/or social services to remain stable in the community. Case management includes the following assistance:

• Initial assessment and annual reassessment of an individual participant to determine the need for any medical, educational, social or other services. Assessments may be done more frequently if medically necessary. These assessment activities include:
- Taking client history;
- Identifying the participant's needs and completing related documentation;
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the participant.
• Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
- Specifying the goals and actions to address the medical, social, educational, and other services needed by the participant;
- Activities such as ensuring the active participation of the participant, and working with the participant (or the participant'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 participant.
• Referral and related activities to help a participant obtain needed services, including activities that help link a participant with:
- Medical, social, educational providers; or
- Other programs offering needed services, making referrals to providers for needed services, and scheduling appointments for the participant.
• Monitoring and follow-up activities:
- Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the participant's needs. These activities, and contact, may be with the participant, his or her family members, providers, or other entities and may be conducted as frequently as necessary, including monthly monitoring to assure that the following conditions are met:
~ Services are being furnished in accordance with the participant's care plan;
~ Services in the care plan are adequate; and
~ If there are changes in the needs or status of the participant, necessary adjustments are made to the care plan and service arrangements with providers.

~ Case 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. Case managers ensure that there is no duplication of services; e.g., the same service is not being delivered by different providers on the same date of service, services are not delivered with greater frequency than is specified in the care plan, etc.

• When a different level of care is required, or when the participant is being discharged from the current level of care, facilitating a seamless transition from the prior level of care to the new level of care.

• Participants may only receive one type of case management at a time. Participants eligible for case management/care coordination through multiple sources (e.g., waivers, IBHP, etc.) must choose the type of case management they prefer to receive.

~ Qualifications of Providers:
This service is delivered by a qualified provider as determined by the Department. Service providers must comply with the limitations of practice imposed by state law, federal regulations, State of Idaho occupational licensing requirements, the provider's professional area of competency, and applicable Department rules, and qualifying criteria are subject to approval by the Department.
• Qualified provider types delivering case management include: Licensed Physician, Licensed Psychiatrist, Licensed Practitioner of the Healing Arts (Advanced Practice Registered Nurse, Nurse Practitioner, Physician Assistant), Licensed Professional Nurse, RN, Certified Psychiatric Nurse, RN, Licensed Social Worker, Licensed Counselor, Licensed Registered Occupational Therapist, Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses), and Licensed Marriage and Family Therapist.
• Minimum Provider Qualifications for case management are providers holding at least a Bachelor's degree in a human services field and meeting the requirements of the Department.

~ Waiver of Freedom of Choice of Providers
As permitted and authorized under section 1915(b)(4) of the Social Security Act, choice of case management providers is waived. Behavioral Health case management will be provided through the Idaho Behavioral Health Plan.
• Participants will have free choice of providers of other medical care under the state 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 a participant's access to other services under the plan; [section 1902(a)(19)]
• Participants 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 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 participants 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 participant 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 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 case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program, except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Remove

Other 1937 Benefit Provided:
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, neglect, and possible Child Welfare involvement. Priority is given to children ages zero (0) through four (4) years and parents of those children who 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.

In accordance with Section 511 of the Social Security Act, priority in service delivery must be given to Idaho communities and families characterized as high risk under the 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.
* Low-income families;
* 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:
Services to the target population may be provided to residents of the following Idaho counties: Ada; Bannock; Bonner; Bonneville; Canyon; Clearwater; Jerome; Kootenai; Nez Perce; Power; Shoshone; Twin Falls.

~ 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 an evidence-based home visiting model approved by Idaho Medicaid; 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))

Add

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

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190808

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.

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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.

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

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

OMB Control Number: 0938-1148
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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.

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

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

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

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

Attachment 3.1- L

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.

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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.

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.

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