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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 17-0009

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form / Summary Form (with 179 like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104



Division of Medicaid & Children's Health Operations

October 24, 2017

Russell S. Barron, Director
Department of Health and Welfare
Towers Building - Tenth Floor
PO Box 83720
Boise, ID 83720-0036

RE: Idaho State Plan Amendment (SPA) Transmittal Number 17-0009

Dear Mr. Barron:

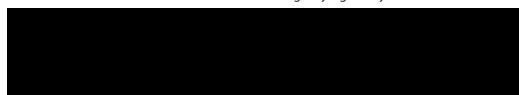
The Centers for Medicare & Medicaid Services (CMS) has completed its review of the enclosed State Plan Amendment (SPA), Transmittal Number 17-0009. This SPA amends Idaho's Enhanced Alternative Benefit Plan (Enhanced ABP) to align the Enhanced ABP's benefit plans with the changes that have been made to the Base Benchmark plan.

This SPA was approved by CMS on October 11, 2017, with an effective date of January 1, 2017. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Idaho State Plan.

If there are any questions concerning this approval, please contact me or your staff may contact Walter Neal at walter.neal@cms.hhs.gov or at (206) 615-2330.

Sincerely,

Digitally signed by David L. Meacham



David L. Meacham
Associate Regional Administrator

Enclosure

cc:
Matt Wimmer, IDHW
Lisa Hettinger, IDHW

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-17-0009

Proposed Effective Date

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

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year		\$
Second Year		\$

Subject of Amendment

Changes made to Enhanced ABP to align with changes to the Base Benchmark 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: Dea Kellom
 Last Revision Date: Sep 14, 2017
 Submit Date: Mar 29, 2017



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Alternative Benefit Plan Populations ABP1

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

Alternative Benefit Plan Population Name:

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 and Disabled Individuals in 209(b) States	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

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

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:



Alternative Benefit Plan

- 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 \$

Disease/Condition/Diagnosis/Disorder.

Other.

Other Targeting Criteria (Describe):

Individuals with health care needs that cannot be met with the Basic ABP
 Pregnant individuals within the income limits above are eligible for full Medicaid
 Pregnant individuals with income 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
 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



Alternative Benefit Plan

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

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

V.20130724



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

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 includes informing each eligible individual of the available benefit options. The Department will inform each individual in a covered population that enrollment in the Enhanced Alternative Benefit Plan is voluntary (i.e., participants may opt in), and that such individuals may opt out of the Enhanced Alternative Benefit Plan at any time and regain immediate eligibility for Medicaid benefits under the Standard State plan or Basic ABP.

The Department will provide such information, in writing, to covered populations, at the following opportunities:

- Initial application for assistance;
- Notice of eligibility determination; and
- Selection of primary care case manager.

As part of the application process, applicants will fill out a "Rights and Responsibility" page that includes areas for them to confirm that they have chosen their plan.

<http://healthandwelfare.idaho.gov/Portals/0/FoodCashAssistance/ApplicationForAssistance.pdf>

The participant handbook, "Idaho Health Plan Coverage," tells participants how they can enroll in another plan, and is available online at <http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx>. This document is also available in hard copy upon request from any Health and Welfare office.



Alternative Benefit Plan

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

An attachment is submitted.

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

The state informs participants of their benefit plan options at the time of enrollment, at redetermination, 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 changing plans.

- 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):



Alternative Benefit Plan

PRA Disclosure Statement

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V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

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:

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:

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.

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.



Alternative Benefit Plan

PRA Disclosure Statement

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V.20130801



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Alternative Benefit Plan Cost-Sharing

ABP4

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

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

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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

V.20130807



Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: - -

Benefits Description

ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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



Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:	Source:	Remove
Primary Care Visit to Treat an Injury or Illness	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	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:	Source:	Remove
Specialist Visit	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Prior Authorization	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	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:	Source:	Remove
Other Practitioner Office Visit	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Prior Authorization	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	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.

Benefit Provided:

Outpatient Facility Fee (e.g., ASC)

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Ambulatory Surgery Center (ASC).

Selected services require prior authorization.

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Selected services require prior authorization.

Benefit Provided:

Urgent Care Centers or Facilities

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

None

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

Benefit Provided:

Chiropractic Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

Six (6) visits

Duration Limit:

None

Scope Limit:

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

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

The 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.

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

Add



Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital Services (e.g., Hospital Stay)

Source:

Base Benchmark Small Group

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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.

Benefit Provided:

Inpatient Physician and Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Selected services require prior authorization.

Benefit Provided:

Radiation Therapy: Inpatient

Source:

Base Benchmark Small Group

Remove

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.

Participants in the optional pregnant individuals group may receive EHB and other 1937 services that are pregnancy-related as described below:

Idaho covers services that are necessary for the health of the pregnant individual and fetus, or that have become necessary because of the individual having been pregnant and services for other conditions that might complicate the pregnancy. Coverage includes prenatal care, delivery, postpartum care, and family planning services. This coverage includes services for the mother or fetus for other conditions that might complicate the pregnancy, including those for diagnoses, illnesses, or medical conditions that might threaten the carrying of the fetus to full term or the safe delivery of the fetus. Pregnancy-related services are covered for a postpartum period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

Idaho does not cover services for pregnant individuals that are medically contraindicated during pregnancy or elective procedures for conditions that do not threaten the health of the pregnant individual, the carrying of the fetus to full term, or the safe delivery of the fetus.

Based on the benefits provided, this group does not meet Minimum Essential Coverage under section 5000A(f)(1)(E) of the Internal Revenue Code on 1986.

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



Alternative Benefit Plan

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

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

Add



Alternative Benefit Plan

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

Collapse All

Benefit Provided:	Source:	Remove
Substance Use Disorder Outpatient Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Other	
Amount Limit:	Duration Limit:	
None	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 or its Contractor 8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses) 9) Registered Nurse		

Benefit Provided:	Source:	Remove
MH/BH Inpatient Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Prior Authorization	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:	None	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Mental Health/Behavioral Health Inpatient Services. Services are not provided in an IMD.		

Benefit Provided:	Source:	Remove
Substance Use Disorder Inpatient Services	Secretary-Approved Other	



Alternative Benefit Plan

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

The Department covers Substance Use Disorder Inpatient Services with services that are the same as the Base Benchmark with the exception of Residential Treatment services.

Services are not provided in an IMD.

Benefit Provided:

Community-Based Rehabilitation Services

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

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

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

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



Alternative Benefit Plan

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) Providers who hold at least a Bachelor's degree, are licensed or certified in their field (i.e., Adult or Children's Certificate in Psychosocial Rehabilitation), and who meet requirements of the Idaho Department of Health and Welfare or its Contractor
- 8) Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
- 9) Registered Nurse

Benefit Provided:

Partial Care

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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



Alternative Benefit Plan

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.

Benefit Provided:	Source:	Remove
MH/BH Outpatient Services: Group Therapy	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	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:		
<input type="text"/>		

Benefit Provided:	Source:	Remove
MH/BH Outpatient: Family and Individual Therapy	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	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:		
<input type="text"/>		

Benefit Provided:	Source:	Remove
MH/BH Outpatient Services: ECT Therapy	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
Prior Authorization	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:

MH/BH Outpatient Services: Med 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:

Add



Alternative Benefit Plan

■ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):

Authorization:	Provider Qualifications:	
<input checked="" type="checkbox"/> Limit on days supply	<input type="text" value="Yes"/>	<input type="text" value="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

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

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

Twenty (20) visits/yr. (habilitative services)

Duration Limit:

None



Alternative Benefit Plan

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."

Benefit Provided:

Durable Medical Equipment

Source:

Base Benchmark Small Group

Remove

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.

Benefit Provided:

Skilled Nursing Facility

Source:

Base Benchmark Small Group

Remove

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.

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

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:	Source:	Remove
Diagnostic Test (X-ray and Lab Work)	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	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:		
<input type="text"/>		

Benefit Provided:	Source:	Remove
Imaging (CT/PET Scans, MRIs, Nuclear Cardiology)	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	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:		
<input type="text"/>		

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).

Benefit Provided:	Source:	Remove
Preventive Services	Base Benchmark Small Group	
Authorization:	Provider Qualifications:	
None	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	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).		

Benefit Provided:	Source:	Remove
Preventive Care/Screening/Immunization	Secretary-Approved Other	
Authorization:	Provider Qualifications:	
None	Selected Public Employee/Commercial Plan	
Amount Limit:	Duration Limit:	
None	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 Enhanced Alternative Benefit Plan includes the following: <ul style="list-style-type: none">- Health Risk Assessment, which consists of:<ul style="list-style-type: none">• 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.		



Alternative Benefit Plan

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).

The Enhanced Alternative Benefit Plan 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.

Benefit Provided:

Diabetes Education

Source:

Base Benchmark Small Group

Remove

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.

Benefit Provided:

Tobacco Cessation Counseling

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Covered in accordance with USPSTF recommendations.

Benefit Provided:

Dietary Counseling

Source:

Secretary-Approved Other

Remove

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



Alternative Benefit Plan

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



Alternative Benefit Plan

11. Other Covered Benefits from Base Benchmark

Collapse All



Alternative Benefit Plan

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

Collapse All

Base Benchmark Benefit that was Substituted:

Residential Treatment

Source:

Base Benchmark

Remove

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

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

This is an IMD.

Base Benchmark Benefit that was Substituted:

Partial Hospitalization

Source:

Base Benchmark

Remove

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

The Department substitutes Community-Based Rehabilitation Services and Partial Care for Partial Hospitalization (part of the EHB 5 Mental/Behavioral Health Outpatient services).

This is an IMD.

Add



Alternative Benefit Plan

13. Other Base Benchmark Benefits Not Covered Collapse All

Base Benchmark Benefit not Included in the Alternative Benefit Plan: <input type="text" value="Non-Emergency Care When Traveling outside the U.S."/>	Source: <input type="text" value="Base Benchmark"/>	<input type="button" value="Remove"/>
Explain why the state/territory chose not to include this benefit: <input type="text" value="Not covered, in accordance with federal statute."/>		
<input type="button" value="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.



Alternative Benefit Plan

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.

Pregnant individuals receive all medically necessary dental services, including the following preventative and restorative services:

* Preventive dental services:

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

* Restorative Dental Services:

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

* Dentures:

- Dentures are covered once every 5 years

Limitations may be exceeded if medically necessary.

Non-pregnant adults who are past the month of their twenty-first (21st) birthday:

- * The Department will cover emergency and palliative dental care required due to accidental injury.

Exclusions - The following non-medically necessary cosmetic services are excluded from payment under the Base Benchmark Benefit Package covered under the State Plan:

- * Drugs supplied to dental patients for self-administration other than those allowed by applicable Department rules.

- * Non-medically necessary cosmetic services are excluded from payment.

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

Other 1937 Benefit Provided:

Outpatient Rehabilitation: OT, PT, SLP Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove



Alternative Benefit Plan

Authorization:

Retroactive Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Other:

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

Services in excess of the Base Benchmark: Rehabilitation Services.

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

Other 1937 Benefit Provided:

Outpatient Habilitation: OT, PT, SLP Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Retroactive Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Other:

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

Services in excess of the Base Benchmark: Habilitation Services.

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

Other 1937 Benefit Provided:

Bariatric Surgery

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

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:

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

Prescription Drugs: In excess of Base Benchmark.

The Department will cover either generic or brand if medically necessary.

The Department provides coverage for the following Medicare-excluded drugs or classes of drugs to all recipients of Medical Assistance under this State plan, including full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

- Prescription drugs, including:
 - Prescription cough and cold agents;
 - Legend therapeutic vitamins, which include injectable vitamin B-12, vitamin K and analogues, and legend folic acid;
 - Oral legend drugs containing folic acid in combination with vitamin B-12 and/or iron salts, without additional ingredients; and
 - Legend vitamin D and analogues.
- Non-legend products, which include:
 - Permethrin
 - Federal legend medications that change to non-legend status, as well as their therapeutic equivalents. The Director determines that non-legend drug products are covered based on appropriate criteria, including safety, effectiveness, clinical outcomes, and the recommendation of the P&T Committee.
 - Other non-legend drug products approved for coverage by the Director of the Department of Health and Welfare based on the determination of the Pharmacy and Therapeutics Committee that the non-legend product is therapeutically interchangeable with legend drugs in the same pharmacological class based on evidence comparison of efficacy, effectiveness, and safety and determined by the Department to be a cost-effective alternative. Information regarding the P&T Committee and covered drug products is posted at <http://healthandwelfare.idaho.gov/Medical/PrescriptionDrugs/tabid/119/Default.aspx>

Excluded drug products include:

- Legend drugs for which Federal Financial Participation is not available



Alternative Benefit Plan

- Ovulation stimulants and fertility-enhancing drugs
- Prescription vitamins, except injectable vitamin B-12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating individuals, and legend folic acid.

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.

The Enhanced Alternative Benefit Plan includes certain enhanced Preventive Health Assistance (PHA) benefits for individuals in the target group, provided in accordance with applicable Department rules.

Enhanced PHA benefits are individualized benefits to address target health behaviors. Authorizations will be managed by the State Medicaid agency. PHA benefits made available under the Enhanced Alternative Benefit 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.

Other 1937 Benefit Provided:

Home Health Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

100 visits per year

Duration Limit:

None



Alternative Benefit Plan

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.

Other 1937 Benefit Provided:

Durable Medical Equipment

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Services in excess of the Base Benchmark: DME

- The 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.



Alternative Benefit Plan

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:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

Two (2) visits

Duration Limit:

Pregnancy and six (6) weeks postpartum

Scope Limit:

None

Other:

Program Description: Medical Care; 1905(a)(6) of the Act – 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 patient to overcome social or behavioral problems that may adversely affect the outcome.

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 Idaho Board of Social Work Examiners. Additional services may be prior authorized.

Other 1937 Benefit Provided:

Targeted Case Management Services: IBHP

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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 in the Idaho Behavioral Health Plan.

- Except in cases where the participant has received in excess of 240 service units in a calendar year, services are not prior authorized, and there is no limitation in amount, duration, or scope.

- The target group consists of members of the Idaho Behavioral Health Plan who are:

1. Adults 18 and older with serious and persistent mental illness or other behavioral health diagnosis; or



Alternative Benefit Plan

2. Children up to age 21 with serious emotional disturbance or other behavioral health diagnosis; and
3. Who demonstrate medical necessity for case management services and require and choose assistance to access services and supports necessary to maintain independence in the community.

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

~ Target group is comprised of individuals transitioning to a community setting, and case management services will be made available for up to the last 60 consecutive days of the covered stay in the medical institution.

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

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

~ Definition of services: [42 CFR 440.169]

Behavioral Health Targeted Case Management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational, and other services. Targeted Case Management 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 more frequently 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 members, 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, educational providers; or
 - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
 - Monitoring and follow-up activities:
 - Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure that the following conditions are met:
 - ~ Services are being furnished in accordance with the individual's care plan;
 - ~ Services in the care plan are adequate; and
 - ~ If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.
- ~ Targeted 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.



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~ Qualifications of Providers:

The Targeted Case Management benefit is provided by a PAHP-contracted and qualified provider as established by the contract, and set forth below for minimum provider qualifications. Service providers are subject to the limitations of practice imposed by State Law, Federal Regulations, The State of Idaho Occupational Licensing requirements, the provider's professional area of competency and as according to applicable Department Rules, approval by the Department and its Pre-paid Ambulatory Health Plan (PAHP) Contractor as established in the contract.

- Minimum Provider Qualifications for Targeted Case Management providers are PAHP contractors: Licensed Physician, Licensed Psychiatrist, Licensed Practitioner of the Healing Arts (Advanced Practice Registered Nurse, Nurse Practitioner, Physician Assistant), Licensed Prof. Nurse, RN, Cert. Psychiatric Nurse, RN, Licensed Prof. Nurse, RN, Licensed Social Worker, Licensed Counselor, Licensed Registered Occupational Therapist, Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses), Licensed Marriage and Family Therapist, holding at least a Bachelor's degree and a Certification or Licensing in their fields and meeting requirements of Idaho Department of Health and Welfare or its Contractor.

~ Waiver of Freedom of Choice of Providers

As permitted and authorized under section 1915(b)(4) of the Social Security Act, choice of targeted case management providers is waived. Behavioral Health targeted case management will be provided by the prepaid ambulatory health plan for the Idaho Behavioral Health Plan.

- Eligible recipients will have free choice of providers of other medical care under the state plan.

~ Freedom of Choice Exception (1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

~ 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:



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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))

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 five (5) 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 only for children through the month of their twenty-first (21st) birthday, and pregnant individuals when 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



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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

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.



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- ~ 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

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

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: Behavioral Intervention: 1905(a)(13)(C) of the Act.

Other services covered by the Department, but not covered by the Base Benchmark: Behavioral Intervention.

- Behavioral intervention is based on a treatment plan developed by the family and a multidisciplinary team that also writes the IEP.

- Behavioral Intervention is used to promote the student's ability to participate in educational services through a consistent, assertive, and continuous intervention process. It includes the development of replacement behaviors with the purpose to prevent or treat behavioral conditions of students who exhibit maladaptive behaviors.

- The behavioral intervention treatment plan is developed and implemented by the multi-disciplinary team. The parents/guardian are included in the development of the plan.

- Qualifications for a Behavioral Intervention Professional are as follows:

- ~ An individual with an Exceptional Child Certificate as defined by State law; or
- ~ An individual with an Early Childhood/Early Childhood Special Education Blended Certificate as defined by State law; or
- ~ A Special Education Consulting Teacher as defined by State law; or
- ~ Habilitative intervention professional who meets the requirements defined by the Department; or
- ~ Individuals employed by a school as certified Intensive Behavioral Intervention (IBI) professionals prior to July 1, 2013, who are qualified to provide behavioral intervention; and
- ~ The individual must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities.



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- Qualifications for a Behavioral Intervention Paraprofessional are as follows:
~ Must be at least eighteen (18) years of age;
~ Must demonstrate the knowledge, have the skills needed to support the program to which they are assigned, and meet the requirements under the “Standards for Paraprofessionals Supporting Students with Special Needs,” available online at the State Department of Education website; and
~ Must meet the paraprofessional requirements under the Elementary and Secondary Education Act of 1965, as amended, Title 1, Part A, Section 1119.
~ A paraprofessional delivering behavioral intervention services must be under the supervision of a behavioral intervention professional or behavioral consultation provider.

Other 1937 Benefit Provided:

Nursing Facility: Custodial Care

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

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

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

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).

Other 1937 Benefit Provided:

Private-Duty Nursing

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

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-



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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:

16 hours per week (limit applies to adults)

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



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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



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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).



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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;



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- 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



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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))



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Additional limitations:

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

Other 1937 Benefit Provided:

Service Coordination: Children with SHCN

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Limited to the target population

Other:

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

Other services covered by the 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;



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- 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.



Alternative Benefit Plan

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))



Alternative Benefit Plan

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:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

None

Scope Limit:

Skilled Nursing Facility services for rehabilitation.

Other:

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

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



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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.

Add



Alternative Benefit Plan

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

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V.20160722



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

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.

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 EPSDT benefits will be provided to participants under 21 years of age (optional):

Behavioral health and dental services are provided through PAHP contracts that 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 children through the month of their twenty-first (21st) birthday be reviewed as an EPSDT request.

Prescription Drug Coverage Assurances

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

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

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

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



Alternative Benefit Plan

Other Benefit Assurances

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

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V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

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 Enhanced 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 Enhanced 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 assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer-sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums.

No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

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.

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.

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V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

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.

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